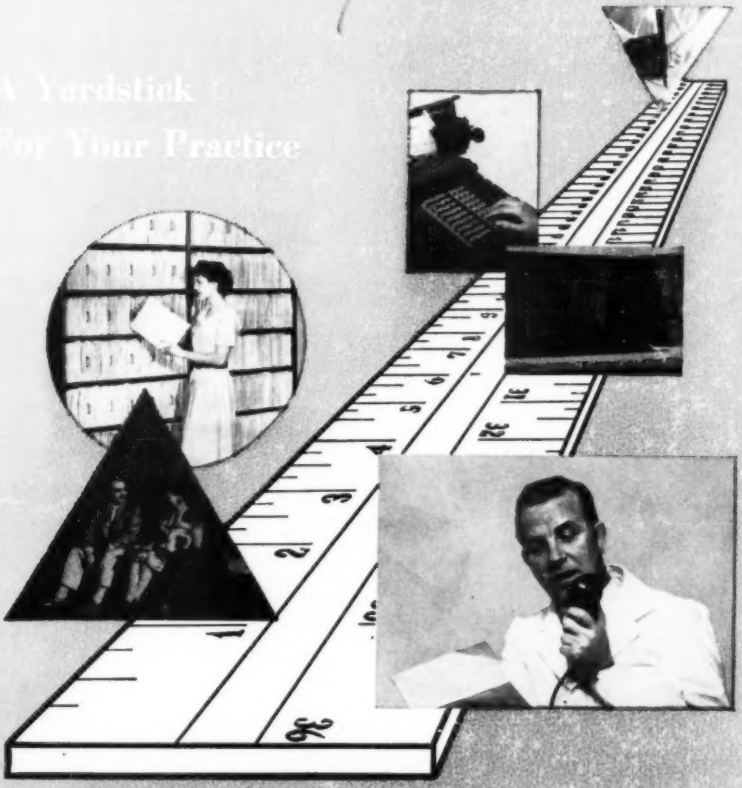
August, 1955

Medical Economics

A Yardstick For Your Practice



Also in this issue: **A Psychiatrist Answers His Critics**

Polio Post-Mortem: What Really Happened

Home-Grown Malpractice Plan Costs Them Less

NEW DRUG

Meratran

(pipradrol hydrochloride)

a unique central motivant with demonstrated subcortical activity subtly returns your emotionally fatigued and depressed patients to their usual level of alertness, interest and productivity

Meratran's action, in easily adjusted doses, is prompt – subtle – comfortable – Its effectiveness is prolonged.

• no appreciable effect on blood pressure and respiration • restores needed sense of well-being • no tolerance or drug habituation • normal appetite undisturbed • no jitters • no apprehension • little or no insomnia • wide range of safety • no rebound letdown

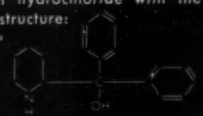
Rx INFORMATION

Meratran

Indications: Emotional fatigue, unhappiness of more common type (financial worry, social stress). Situational stress or *mild* depression. Adjunctive therapy in certain psychoses and psychoneuroses.

Composition: alpha-(2-piperidyl) benzhydrol hydrochloride with the following structure:

T. M. MERATRAN



Dosage: For emotional fatigue and mild depression, 1 to 6 mg. daily. *Individual patient response must be observed and daily dosage and duration of administration adjusted to patient response.*

Supplied: Small pink tablets containing: 1 mg. Meratran (pipradrol) hydrochloride.* Bottles of 100.

* Alpha-(2-piperidyl) benzhydrol hydrochloride.

Merrell
Since 1828

PIONEER IN MEDICINE FOR OVER 125 YEARS

THE WM. S. MERRELL COMPANY

New York • ST. THOMAS, ONTARIO • Cincinnati

AUGUST, 1955

Medical Economics

AN INDEPENDENT NATIONAL BUSINESS MAGAZINE FOR PHYSICIANS.

MORE ►

CONTENTS *(Cont.)*

DEPARTMENTS

PANORAMA INDEX

EPA NBP

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Panorama

Test-tube births get medical endorsement • Panel plans still on the rise • The subtle art of heterophemia • Committee reports A.M.A. in good shape • What price over-specialization? • Handling liability suits

M.D. Draft: What Now?

Now that the controversial doctor draft is on the books for another two years, Pentagon officials aren't itching to invoke it. But if they do, some 2,000 Priority 3 physicians between the ages of 35 and 40 may be in uniform next July.

Assistant Secretary of Defense Frank B. Berry and his aides are hoping that quotas will continue to be met by voluntary enlistments. So far, says a spokesman, enlistments (mostly by immediately draftable M.D.s) have been above expectations.

But if recruitment falls off sharply, the stage will be set for an all-out Pentagon grab at available men.

Dr. Berry's office tempers this possibility, however. It figures it can get by until next April without dipping into the draft ranks. At that time, a first call will probably go out for 300 to 400 physicians in Priority 3 (deferred as essential or physically unfit) and for a handful of holdovers from Priorities 1 and 2 (those who had World War II training-deferment or Federal training aid).

After that, the draft tempo will have to pick up considerably if the 2,000-man quota is to be met.

While the present statute seems to go easy on doctors "previously deferred for physical reasons," Pentagon officials are worried that some former 4Fs won't bother to read the fine print.

As the law now stands, a doctor over 35 who *previously applied for a commission* and was classified 4F won't be liable for call. But if he was rejected *as a draftee*, he's likely to get another Presidential greeting in the mail and to wind up in uniform by next July.

Of course, physicians over 46 are exempt under the new legislation. And, barring national emergency, those in Priority 4—with at least seventeen months' active duty—won't be touched.

Asked what will happen to doctor-draft legislation after 1957, defense officials shake their heads. "It'll

never get through Congress again," says one spokesman flatly.

"The only real hope the military has for a continued supply of experienced physicians," he points out, "is to make career-service more attractive. We'll just have to up the pay for medical officers."

Artificial Insemination Gets Formal Backing

Test-tube births—long the subject of ethical and legal controversy—have now won official medical endorsement. It comes, fittingly, from the American Society for the Study of Sterility (an organization with upwards of 500 M.D.-members). Says a recently passed society resolution:

Artificial insemination is a "completely ethical, moral, and desirable form of medical therapy," as long as it meets the following conditions:

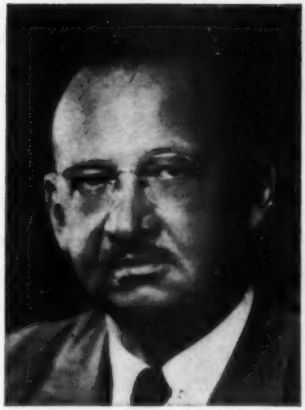
1. Both husband and wife really want it;

2. The physician searches carefully for a donor who's genetically and biologically satisfactory; and

3. The physician is convinced that the couple will make desirable parents.

Why did the society decide to take an official stand now? Because of "recent publicity in the lay press and requests for legal opinions," explains Dr. John O. Haman of San Francisco, 1954-55 president of the organization.

One legal opinion that the society obviously wanted to counteract was handed down late last year by Judge Gibson E. Gorman of the Cook County (Ill.) Superior Court. Ruling that artificial insemination could be grounds for divorce, the judge added that "donor insemination, with or without the consent of the husband, is contrary to public policy and good morals."



DR. JOHN O. HAMAN

A green light for insemination

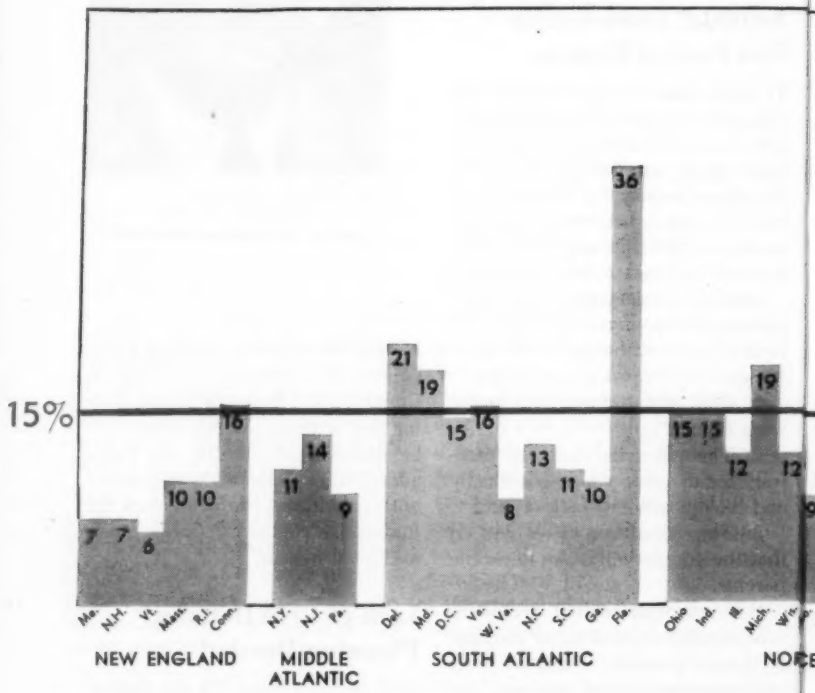
Lack of Civil Defense Planning Decried

Civil defense plans for the deployment of medical personnel in case of atomic attack are woefully inadequate. So says Dr. Paul R. Hawley, head of the American College of Surgeons, who adds: "If an attack

came tomorrow, *no one* in civil defense would be able to say how the medical care problem should be handled."

In testifying recently before a Senate subcommittee on civil defense, Dr. Hawley said, "Medical planning for the next war is follow-

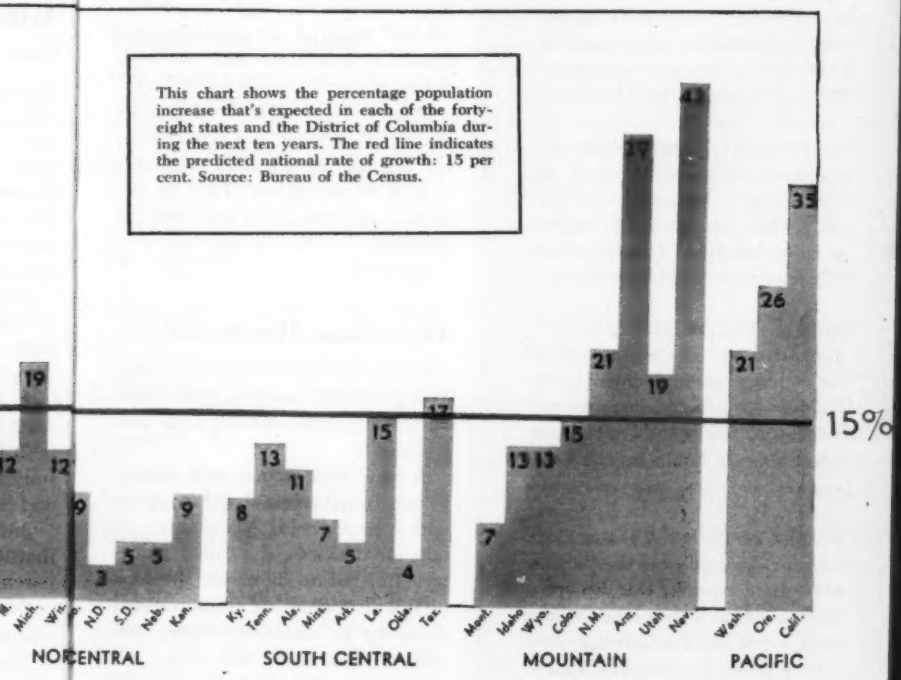
Our Growing Population: A State-by-Stat



• A physician looking for a populous place to stake a medical claim might be wise to heed Horace Greeley's century-old advice and head West. For once again, this is the section of the country that's growing the fastest. It's expected that by 1965, the population of California, Oregon, and Washing-

ing exactly the same pattern as that of previous wars: The armed forces will withdraw from the medical resources of the country all that they require for their exclusive use . . . and the . . . civil population will [have to] get along as best it can with what's left." [MORE ▶

Look at What You Can Expect by 1965



ton State, for example, will increase by 27 per cent, or 5.5 million. On the other hand, the Census Bureau predicts that all three Middle Atlantic States —New York, New Jersey, and Pennsylvania—will actually lag behind the national rate of growth over the next decade.

Snapshots

LOCATION PROBLEM: Doctors can be *too* careful about vaccinating little girls where it won't show later: An Omaha moppet recently brought home a note of complaint from her school nurse. It said, "Our records show your daughter was vaccinated twice, but I can't find vaccinations. Please inform me of their location."

Rx RECORD is reported by the magazine American Druggist. It says that in a recent two-week period, family doctors accounted for an unprecedented 79.8 per cent of all prescriptions written in the U.S.

PHYSICALS FOR DRIVERS: New York State may require all car drivers to take periodic medical exams. Governor Averell Harriman recommended such a law this year and failed to get it; but he says he'll try again in '56.

WELFARE DIDO: A young Englishman who applied to the National Health Service for free dentures, after losing his first set while swimming, found that a welfare state can draw a pretty fine line. The N.H.S. refused to give him any new teeth, on grounds he had "exercised lack of good judgment in swimming in a rough sea."

Since it's the civilian population that will bear the brunt of atomic attack, such a course can lead only to "total disaster," Dr. Hawley warned. "No longer can we afford the luxury of four separate and distinct medical plans for war—one each for the Army, the Navy, the Air Force, and the civil population—and all competing, each with the other, for personnel and material. In such competition . . . it is evident that the civil population will come off fourth best."

What's desperately needed, says the A.C.S. director, is a master-plan for pooling *all* medical resources in case of emergency. This, he believes, can come about only through intensive, national preparation at a "high level."

Three-Ring House Call

Does it pay to hoodwink the doctor? The following story—a true one—may help convince some people that it doesn't:

A New York woman was visiting Miami Beach when she came down with a heavy cold. Not wanting to take any chances, she called a doctor. But before he came, she took off her three diamond rings, wadded them up in cleansing tissue, and stuffed them under her pillow. "I didn't want the doctor to know I was wealthy enough to own three diamond rings," she explained later. "If he saw the rings, I was afraid he would charge me more."

She may have succeeded in this

maneuver. But as it turned out, it cost her three diamond rings. No, the doctor didn't get them. The woman got mixed up as to which wad of tissue contained the rings. After the doctor had gone, she threw the wrong wad out with the trash.

And she never got the rings back, either.

Panel Plans by States

Despite the opposition of organized medicine, closed-panel prepay plans continue to spread. Schemes modeled after New York's Health Insurance Plan and California's Kaiser Foundation now exist in eleven states and the District of Columbia. Here's the tally:

California leads with six. Washington State has three. Minnesota and New York have two apiece. Colorado, Illinois, Kentucky, Missouri, Oklahoma, Pennsylvania, Wisconsin, and Washington, D.C., have one each.

'Cancer Patients Have Right to Know'

The latest argument for telling cancer patients what's wrong with them comes from a Beverly Hills, Calif., psychiatrist. Here's why Dr. Judd Marmor, writing in his county medical society bulletin, votes for candor —except when there are "strong overriding reasons" against it:

1. Patients "have a legal right to know the truth." [MORE▶

Snapshots

TWO-TIMED: M.D.s in towns like Evansville, Ind., have had to disappoint more than one young mother this summer who rejoiced prematurely at having her new offspring born on a particular day, say, July 4th. Reason: Though Evansville is on Daylight Saving Time, its physicians are required to use Central Standard Time for recording birth and death certificates.

WILL-SHY: One-half of all professional men fail to make wills, finds a Columbia University survey. Have you made yours?

YOUR CAR WILL COST nearly $40 more to operate this year than last, says the American Automobile Association. Estimated current upkeep on the average medium-priced car: 3.5 cents a mile (for variable costs, like gas, oil, and maintenance), plus $1.64 a day (for such fixed costs as depreciation, insurance, etc.).

DRUGS GALORE: The average American physician gets over 3,000 pieces of pharmaceutical mail every year, with drug samples accompanying nearly a third of them, estimates a spokesman for E. R. Squibb & Sons.

2. "Most patients . . . apparently want to be told."

3. "Patients who have cancers which are cured should know what they had, so they can encourage other people and help combat the myth of its incurability."

4. "Patients who know what they have are apt to be more cooperative in follow-up care and treatment."

5. "Patients with certain kinds of cancer . . . cannot help knowing or suspecting the truth when they awaken to find that surgery has been performed. To attempt to deny the obvious in such instances may actually intensify their anxiety by making them feel that the truth is too terrible to be mentioned."

6. "Patients often take the news of cancer far better than doctors anticipate . . . The power of human beings to adapt themselves to the inevitable should never be underestimated."

7. "Patients are entitled to know if their life span is limited, so they can arrange their affairs and do the things they may wish to do in the . . . time left to them."

Tax Cut Predicted

Are tax reductions likely in '56? A good many authorities say they are, despite the President's repeated assertion that he wants a balanced budget. Their reasoning: In an

Upjohn

Gradual and sustained lowering of blood pressure:

Reserpoid

TRADEMARK FOR THE UPJOHN BRAND OF RESERPINE

(Pure crystalline alkaloid)

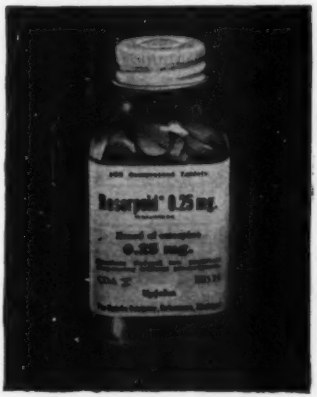
Each tablet contains:

Reserpine ..... 0.1 mg.
or 0.25 mg.
or 1.0 mg.

Supplied:

Scored tablets
0.1 and 0.25 mg. in bottles of 100 and 500
1.0 mg. in bottles of 100

The Upjohn Company, Kalamazoo, Michigan



from futility to utility . . . in rheumatoid disorders

Acetycol provides welcome relief to the patient suffering from the stiffness and pain of arthritis and related rheumatoid disorders. With Acetycol his range of pain-free mobility is broadened and his entire outlook brightens. He is able again to resume more normal activities in work and play.

The effectiveness of Acetycol is based on synergism between aspirin and para-aminobenzoic acid. These two agents in combination achieve high salicylate blood levels on relatively low dosage. The addition of salicylated colchicine extends the effectiveness of Acetycol to cases of a gouty nature.

Acetycol also contains three important vitamins often lacking in older and rheumatic patients: these are ascorbic acid, to prevent degenerative changes in connective tissues; thiamine and niacin, for carbohydrate utilization and relief of joint pain and edema.

Usual dosage—1 or 2 tablets three or four times a day.

Each Acetycol tablet contains:

Aspirin	325.0 mg.
Para-aminobenzoic acid	162.0 mg.
Colchicine, salicylated	0.25 mg.
Ascorbic acid	20.0 mg.
Thiamine hydrochloride	5.0 mg.
Niacin	15.0 mg.

Supplied: Bottles of 100 and 500.

Acetycol

TRADEMARK

to relieve rheumatic pain

WARNER-CHILCOTT

election year, political considerations are bound to come first.

"The Democratic fight to cut taxes this year was 'for the record'—wasn't pushed all out," says Business Week. "It will be different in 1956 . . . Democrats will be playing for keeps then. And Eisenhower will be under heavy pressure from his own party to take the lead and get credit for the cuts."

Dog-Lovers Abuse M.D.s

Anyone who thinks antivivisection is a dead issue may well consider the recent experience of a research team of University of Minnesota physicians:

The doctors involved operated on the defective heart of a 13-year-old boy who had been given only a year to live. The youngster is now well and normal. But the members of the research team are still feeling the aftereffects of the operation. For, somehow, the antivivisectionists learned that, during the course of it, a dog's lung had been used to provide oxygen for the patient's bloodstream. Their letters (mostly anonymous) have been pouring in ever since. Here are some unedited quotations:

¶ "If some day some doctor, *not you*, will decide to torture you by cutting out one of your lungs to save someone else's life, it will come

home to you how you have tortured helpless creatures."

¶ "I could hope for you M.D.s that you all meet with horrible heart deaths and soon. You rascals are so satiated with sadism that you have lost all sense of pity and fairness."

¶ "If some of them could only give you sadists some diseases so you would suffer long and unbearable torture—for you it would be a blessing."

¶ "I hope that the child—likewise also you—died and have that on your mind until the end of your days."

¶ "Why don't you all go back to Russia where they are doing these things, for you are not fit to be an American, any of you."

One of the team's surgeons says he felt "surprise and disappointment" at the volume and intensity of these attacks. But he plans—not surprisingly—to continue to use animals in order to save human lives.

Over-Specialization

To show how far specialization is carried in some hospitals today, Dr. Leland S. McKittrick of Brookline, Mass., reports this case in the New England Journal of Medicine:

"A general surgeon in a New England hospital had made a diagnosis of acute appendicitis; but when the abdomen was opened, it was found that the patient had an

Gastric Hyperacidity: etiology

People being people, environmental factors contributory to gastric hyperacidity are hard to remove, even when their role is clearly defined. But, the physician has a sure, simple—even pleasant—way of relieving the acid distress caused by:

- dietary indiscretion
- nervous tension
- emotional stress
- food intolerances
- excessive smoking
- alcoholic beverages

Gelusil promptly and effectively controls the excessive gastric acidity of "heartburn" and chronic indigestion. And it affords equally rapid relief in peptic ulcer. Sustained action is assured by combining magnesium trisilicate with the specially prepared aluminum hydroxide gel.

Free from constipation: Gelusil's aluminum hydroxide component is specially prepared: the concentration of aluminum ions is accordingly low; hence the formation of astringent—and constipating—aluminum chloride is minimal.

Free from acid rebound: Unlike soluble alkalies, Gelusil does not over-neutralize or alkalinize. It maintains the gastric pH in a mildly acid range—that of maximum physiologic functioning.

Dosage—2 tablets or 2 teaspoonfuls two hours after eating or when symptoms are pronounced. Each tablet or teaspoonful provides: 7½ gr. magnesium trisilicate and 4 gr. aluminum hydroxide gel.

Available—Gelusil Tablets in packages of 50, 100, 1000 and 5000. Gelusil Liquid in bottles of 6 and 12 fluidounces.

Gelusil®

Antacid • Adsorbent

WARNER-CHILCOTT

ovarian cyst with a twisted pedicle rather than appendicitis. This condition fell within the field of gynecology.

"According to the rules of the hospital, the general surgeon was not allowed to do gynecologic operations. It was necessary to call in a gynecologist to remove the ovarian cyst. The surgeon was then permitted to remove the appendix and close the abdomen."

A Case of Heterophemia

Sometimes, the only way for a doctor to keep faith with a patient is through a bit of equivocation. At least that's how it appears to the Norfolk Medical News (of Boston), which cites the following hypothetical—but not unlikely— situation:

"Alice works for the American Chop Sticks Company. Through payroll deduction she subscribes to the group health and accident coverage underwritten by the John Quincy Adams Insurance Co. This coverage enables Alice to go to the physician of her choice for her coughs, corns, and what-have-you . . . The physician collects by simply completing a certificate, which, among other pertinent data, requires a diagnosis."

But suppose, says the News, that Alice "does not have a cough or a corn, but a what-have-you. She knows the physician will respect her

need for professional secrecy. [But] she also knows that the certificates are processed in the plant where she works, and that [discovery by] the girls who process them of a what-have-you in a fellow employe will be cause for a choice bit of *oui-dire* in the *salle a poudre* . . ."

Faced with this situation, how can the physician protect Alice? The journal points out that even the Principles of Medical Ethics don't challenge the employer's right to examine such insurance claims; so the only solution, it suggests, is for the practitioner simply to write in a diagnosis of *heterophemia*. "If the size of the claim warrants a second look by the insurance company, the private matter can then be divulged at headquarters."

And what might heterophemia be? Merely the "saying of one thing when another is meant," the News explains.

Doctor-Committee Finds A.M.A. Well Run

The A.M.A. has become such a complex organization that some of its officers have talked of hiring a firm of management consultants to find out whether it's being run as efficiently as possible. But a committee of three physicians that recently reviewed all activities of the Association's Chicago headquarters insists

that "it would be foolish" to make such a survey.

By and large, reports the committee, the A.M.A.'s machinery runs smoothly; and if there *are* organizational ills, they can best be diagnosed by "critical physician members."

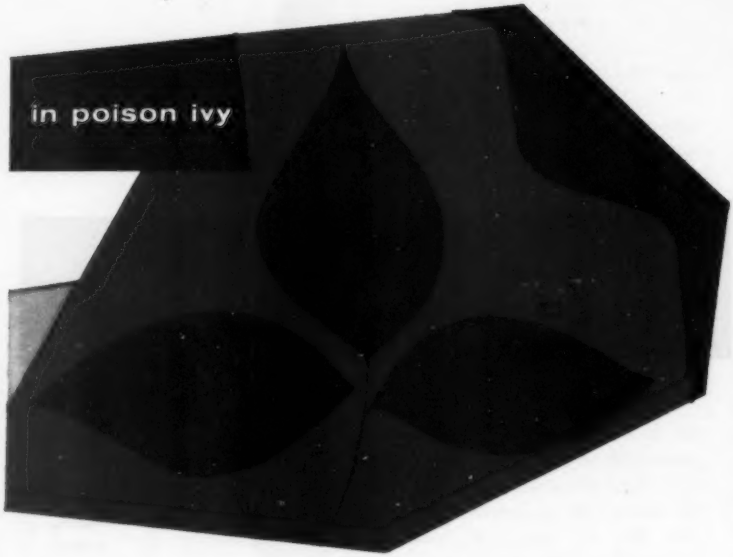
Fulfilling this critical function themselves, the three doctors (who were appointed to look into the matter by the Speaker of the House of Delegates) suggest a major economy move:

Let the A.M.A. get out of the printing business, sell its old presses, and arrange to have the bulk of its literature printed on the outside. By so doing, it would not only save money; it would also be able to reclaim three floors of badly needed office space in the headquarters building.

Drs. Harlan English, D. H. Witte, and E. P. Weigel, who comprise the committee, also offer some other observations:

¶ The Association's public relations program "is in most capable hands." (In one recent ninety-day period, for example, the department helped outside writers prepare over 100 articles for mass-circulation magazines. And none of these articles, says the committee, was "too critical of medicine.")

¶ The A.M.A. does a good job of acting as a "clearing house for research data." (The committee suggests that doctors who give money to the various [MORE ON 223]



topical corticosteroid-antibiotic therapy

florinef-[redacted]

Squibb Fludrocortisone Acetate With Spectrocin (Squibb Neomycin-Gramicidin)

almost immediately relieves the intolerable itching, and reduces the hazard of spreading the eruption through scratching.

10 to 25 times more potent than hydrocortisone, Florinef-S usually clears inflammation and reduces eruption within 12 hours.

provides prophylactic and therapeutic action against secondary infection.

Florinef-S and Florinef are also effective in many cases of *poison oak, poison sumac* and *primrose poisoning.*

Supply: *Florinef-S Lotion*, 0.05 and 0.1 per cent, in 15 ml. plastic bottles.
Florinef-S Ointment, 0.1 per cent, in 5 gm. and 20 gm. tubes.

Florinef Lotion, 0.05, 0.1, and 0.2 per cent, in 15 ml. plastic bottles.
Florinef Ointment, 0.1 and 0.2 per cent, in 5 gm. and 20 gm. tubes.

SQUIBB

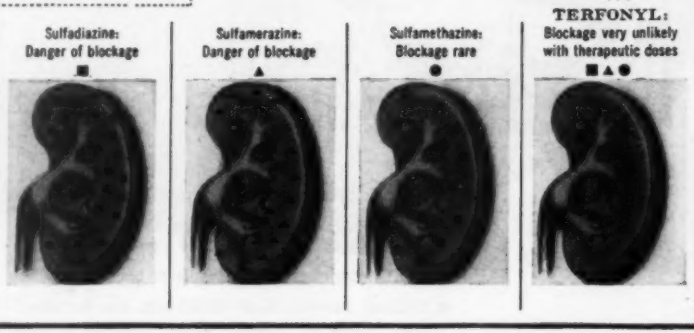
"FLORINEF" AND "FLORINEF-S" ARE SQUIBB TRADEMARKS

TERFONYL

Sulfadiazine
Sulfamerazine
Sulfamethazine

FOR SAFER SULFONAMIDE THERAPY....

Low Renal Toxicity



With usual doses of Terfonyl the danger of kidney blockage is virtually eliminated. Each of the three components is dissolved in body fluids and excreted by the kidneys *as though it were present alone* The solubility of Terfonyl is an important safety factor.

Terfonyl contains equal parts of sulfadiazine, sulfamerazine and sulfamethazine, chosen for their high effectiveness and low toxicity.

Terfonyl Tablets 0.5 Gm. Bottles of 100 and 1000

Terfonyl Suspension, 0.5 Gm. per 5 cc.
Appetizing raspberry flavor • Pint bottles

SQUIBB A NAME YOU CAN TRUST

"TERFONYL" IS A SQUIBB TRADEMARK

Any patient sick enough to need broad spectrum antibiotics deserves the added protection against monilial superinfection afforded by

Mysteclin

(Mi-stek-lin)

STECLIN-MYCOSTATIN

(SQUIBB TETRACYCLINE-NYSTATIN)

Each Mysteclin capsule contains 250 mg. of Steclin (Squibb Tetracycline) Hydrochloride, the broad spectrum antibiotic which is better tolerated and produces higher blood and urinary levels than its analogues, and 250,000 units of Mycostatin (Squibb Nystatin), the first safe antibiotic effective against fungi.

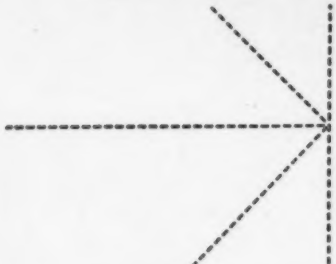
Minimum adult dose: **1 capsule q.i.d.**

Supply: **Bottles of 12 and 100.**

better tolerated broad spectrum
antibacterial therapy
plus
antifungal prophylaxis
in one capsule

. . . and Mysteclin costs the patient only a few pennies more per capsule than other broad spectrum antibiotics which do not provide antifungal prophylaxis.

Areas of Clinical Study / One of a series



ANEMIA OF INFANCY

Recently completed—1954—studies [1,2] again confirm the unique value of Roncovite (cobalt-iron) in the prevention and treatment of infant anemia.

Clinical results show that routine administration of Roncovite can completely prevent the iron deficiency which so frequently develops in the first six months of life.

RONCOVITE (*Cobalt-Iron*) *has introduced a wholly new concept in anti-anemia therapy. It is based upon the unique hemopoietic stimulation produced only by cobalt. The application of this new concept has led to marked, often dramatic, advances in the successful treatment of many of the anemias.*

EFFECTIVE

"It is a significant fact that none of the... cases receiving iron as well as cobalt required additional iron therapy and that the haemoglobin levels of this group remained consistently and significantly higher than those in any other group after the age of 4 months."[1]

"...there can be no doubt that the average hemoglobin values...are greater in the cobalt-iron (Roncovite) treated group."[2]

PATIENT SATISFACTION

"...the mothers of these anaemic infants frequently stated spontaneously that the children were much improved, with increased appetite and vigour. It seems possible, therefore, that even if anaemia in premature infants does not usually produce marked symptoms, there is a subclinical debility which becomes more evident in retrospect."[1]

SAFETY

"There was no evidence of toxicity in any case under treatment:...There is nothing to suggest that cobalt in any way impairs the general progress or rate of weight gain in premature infants in the dosage employed."[1]

"The babies were closely observed daily for ill effects of the medication while at the premature unit and when they returned for check ups. None of them showed harmful effects despite the large doses...A few of the babies ...have been followed for more than 100 days with no ill effects noted."[2]

SUPPLIED:

RONCOVITE DROPS

Each 0.6 cc. (10 drops) provides:
Cobalt chloride.....40 mg.
(Cobalt 9.9 mg.)
Ferrous sulfate.....75 mg.

RONCOVITE TABLETS

Each enteric coated, red tablet contains:
Cobalt chloride.....15 mg.
Ferrous sulfate exsiccated.....0.2 Gm.

RONCOVITE-OB

Each enteric coated, red capsule-shaped tablet contains:
Cobalt chloride.....15 mg.
Ferrous sulfate exsiccated.....0.2 Gm.
Calcium lactate.....0.9 Gm.
Vitamin D.....250 units

DOSAGE:

One tablet after each meal and at bedtime. In children one year or older 0.6 cc. (10 drops); infants less than one year 0.3 cc. (5 drops): once daily diluted with water, milk, fruit or vegetable juice.

1. Coles, B. L., and James, U.: Arch. of Disease in Childhood *29*:85 (1954). Coles, B. L., and James, U.: Journal-Lancet *75*:79 (March) 1955. Coles, B. L.: Arch. Disease in Childhood *30*:121 (April) 1955.
2. Quilligan J. J., Jr.: Texas State J. Med. *50*:294 (May) 1954.

Bibliography of 192 references available on request.

RONCOVITE

The original, clinically proved cobalt-iron product.

LLOYD

BROTHERS, INC.

Cincinnati, Ohio

In the Service of Medicine Since 1870

The Full-Liquid Diet pulls its own weight!

Packing good nutrition into the full-liquid diet for your patients who must stay on it a long time is difficult. But, with a blender or egg beater, most foods can be used.

Mix the same foods many ways—

Strained chicken in milk makes "bisque" —in tomato juice it's "creole." Add skim milk powder for a protein bonus.

Your patient may like cottage cheese whipped into milk flavored with chocolate and mint, or he can blend it with cranberry juice sparked with lime.

Strained carrots go in milk, broth, or pineapple juice. Flavor the milk blend with nutmeg, the broth with parsley, and the juice with cinnamon and brown sugar.

Strained fruits in fruit juices do well with a squeeze of lemon.

Then serve them up with dash—

Clear drinks look good in gaily painted glasses. But hide a drab-looking mixture in a napkin-wrapped jam jar.

Add a bright plastic straw. And for garnish, try a sprinkle of spice, a spoonful of sherbet, a dab of whipped cream, or a lemon slice hooked on the glass.

Of course, only you can tell your patient *just which foods* he can and must have, but these ideas can help guide him within the limits you set.

After
severe infectious disease,
fractures and other trauma,
prolonged antibiotic therapy,
serious vitamin depletion,
second and third degree
burns, surgery

hasten
convalescence
with

STRESSCAPS*

Stress Formula Vitamins *Lederle*

Patients who suffer unusual physiologic stress need proper vitamin supplementation to hasten their convalescence. STRESSCAPS (based on the formula suggested by the National Research Council) provide the necessary vitamins in a *dry-filled* capsule for rapid and complete absorption. Average dose: in convalescence—1 capsule daily; in severe conditions—2 capsules daily.

Each capsule contains:	
Thiamine Mononitrate (B_1)	10 mg.
Riboflavin (B_2)	10 mg.
Niacinamide	100 mg.
Ascorbic Acid (C)	300 mg.
Pyridoxine HCl (B_6)	2 mg.
Vitamin B_{12}	4 mcgm.
Folic Acid	1.5 mg.
Calcium Pantothenate	20 mg.
Vitamin K (Menadione)	2 mg.

Lederle LEDERLE LABORATORIES DIVISON *American Cyanamid company* PEARL RIVER, NEW YORK

*REG. U.S. PAT. OFF.

to support recovery, speed convalescence

Tetracyn SF*

BRAND OF TETRACYCLINE

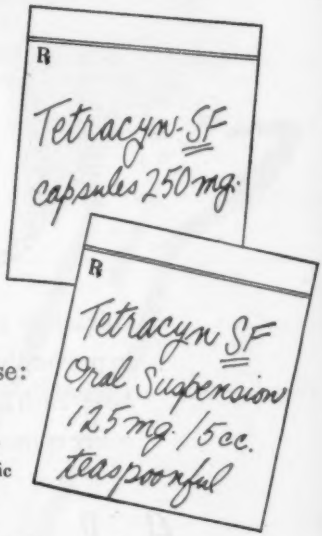
the leading broad-spectrum antibiotic, discovered by Pfizer

with water-soluble vitamins in combinations originated by Pfizer

For patients with infections, "one must aim at maintaining the normal daily nutritional requirements, replacing previous depletions and current losses, and supplying whatever increased requirements may be related to the nature of the illness."[1] This is the concept of "treating the 'whole' patient."[2]

Tetracyn SF has antibiotic effectiveness equal to that of Tetracyn® alone[3] and, in the hands of thousands of physicians, has shown

Equivalent Blood Levels[3]
Superior Toleration[4]
Accelerated Recovery[5]



Two effective dosage forms for oral use:

Terramycin† SF* *is also available.*

Tetracyn SF and Terramycin SF are formulated to provide with the minimum daily dose of each antibiotic (1 Gm. of Tetracyn or Terramycin) the stress vitamin formula recommended by authorities on nutrition.[1]

1. Pollack, H., and Halpern, S. L.: Therapeutic Nutrition, Prepared in Collaboration with the Committee on Therapeutic Nutrition, Food and Nutrition Board, National Research Council, Washington, D. C., 1952. 2. Martí-Ibáñez, F.: Antibiotic Med. *1*:247 (May) 1955. 3. Dumas, K. J.; Carlozzi, M., and Wright, W. A.: Antibiotic Med. *1*:296 (May) 1955. 4. Milberg, M. B., and Michael, M., Jr.: Ann. New York Acad. Sc., In press. 5. Prigot, A.: Ibid.

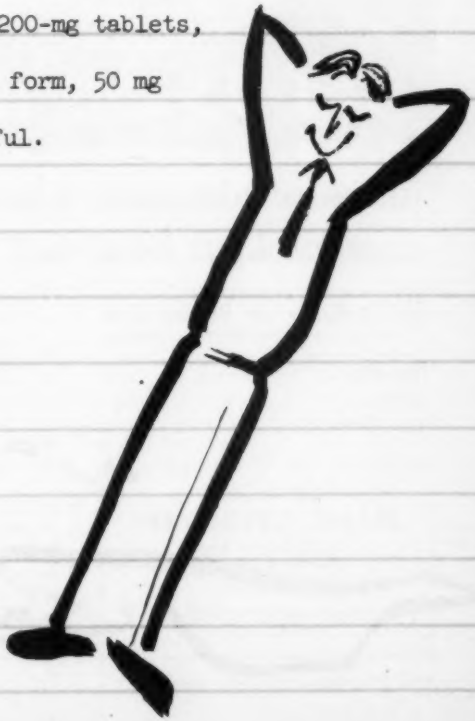
†Brand of oxytetracycline
*Trademark for Pfizer brand of antibiotics with vitamins.

Pfizer PFIZER LABORATORIES, Brooklyn 6, N.Y.
Division, Chas. Pfizer & Co., Inc.

Clinically proven to be highly effective in prevention and treatment of impetigo, heat rash, ammoniacal dermatitis and other common skin affections of infancy.

Johnson & Johnson

you can relax your patient and enjoy peace of mind yourself when you prescribe Noludar 'Roche' as a sedative (or in larger dosage, as a hypnotic). There is little danger of habituation or other side effects, because Noludar is not a barbiturate. Available in 50-mg and 200-mg tablets, and in liquid form, 50 mg per teaspoonful.



Sheep bring sleep to a few ...

but relaxation brings sleep to almost everyone. Noludar relaxes your patient and usually induces sleep within one half to one hour, lasting 6 to 7 hours. Clinical studies on more than 3,000 patients have demonstrated the usefulness of Noludar for the relief of nervous insomnia and daytime tension. Noludar 'Roche' is not a barbiturate. Noludar™

-- brand of methyprylon (3,3-diethyl-5-methyl-2,4-piperidinedione)

Hoffmann - La Roche Inc

Nutley · N.J.

Hypo-allergenic, one-grain cereal ... an ideal first food for infants

Now Beech-Nut adds a fifth variety to its pre-cooked cereals for babies—*Rice Cereal.*

Beech-Nut Rice Cereal is made from selected rice and rice flour. It is a *one-grain* cereal, especially indicated for infants with a family history of allergy. Bland in flavor and super-smooth, it is readily accepted as a first food and easily digested.

Formulated in consultation with leading pediatricians and nutritionists, Beech-Nut Rice Cereal is fortified with essential minerals and B vitamins in correct proportions and assimilable form.

You are invited to send for a set of file cards giving comprehensive laboratory data on all five Beech-Nut Pre-cooked Cereals.

THRIFTY, CONVENIENT! The thrifty 4-ounce size of the Beech-Nut package offers an inexpensive way to vary Baby's cereal menu. The new pouring spout is easy to open and snaps tight closed after use.

BEECH-NUT
PRE-COOKED CEREALS
RICE • OATMEAL
BARLEY • CORN
CEREAL FOOD
Beech-Nut Packing Company
Canajoharie, N. Y.

prescribe *a full measure of comfort for anorectal patients with*

DESITIN®

hemorrhoidal SUPPOSITORIES with cod liver oil

In boxes of 12 foil-wrapped suppositories

samples yours for the asking

DESITIN SUPPOSITORIES quickly soothe, protect, lubricate the distressed anorectal mucosa to provide.....

- **gratifying comfort in hemorrhoids** (non-surgical)
- **rapid, sustained relief of pain, itching and spasm without styptics, local anesthetics or narcotics, therefore do not mask serious rectal disease**
- **reduced engorgement, bleeding • safe, conservative**

DESITIN CHEMICAL COMPANY • 70 Ship Street, Providence 2, R. I.

When a "tension syndrome"
results in gastrointestinal distress . . .

Prydonnal*

atropine, hyoscyamine, scopolamine, phenobarbital

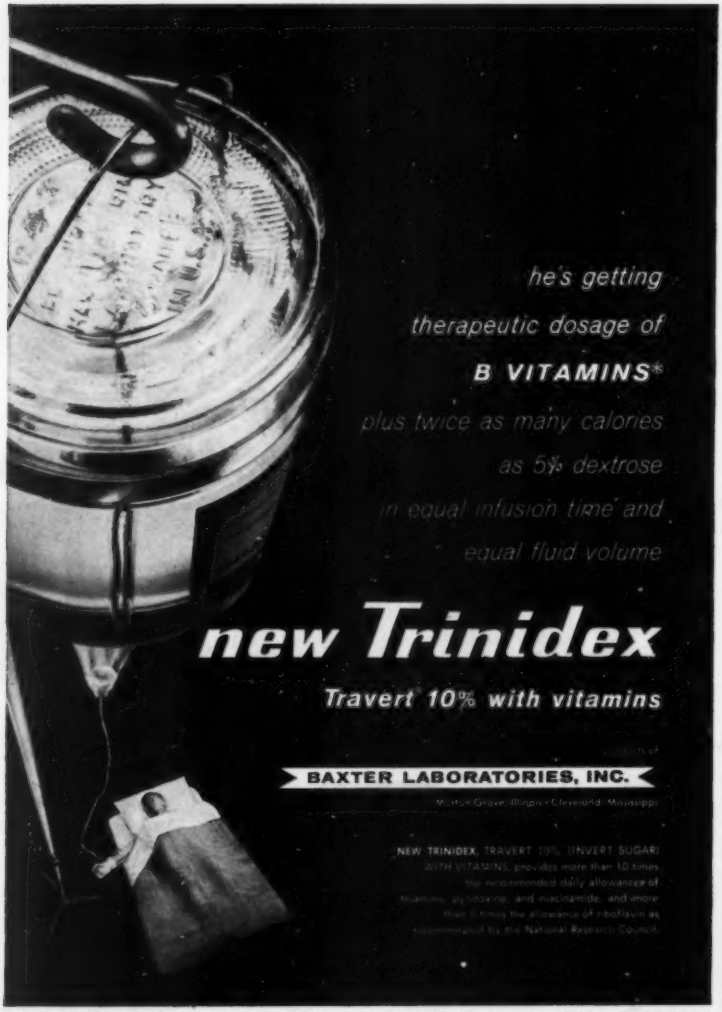
Spansule*

brand of sustained release capsules

A single 'Prydonnal' *Spansule* capsule q12h provides 24-hour antisecretory-antispasmodic-sedative action that assures your patient distress-free days and undisturbed sleep throughout the night.

made only by
Smith, Kline & French Laboratories, Philadelphia
the originators of sustained release oral medication

*T.M. Reg. U.S. Pat. Off. Patent Applied For.



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the Resions

...specifics in diarrhea

The RESIONS offer two effective compounds for treatment of almost any diarrheal condition found in clinical practice.

The RESIONS act by ion exchange . . . to attract, bind and remove toxic materials in diarrheas caused by food or bacterial toxins; by prolonged use of certain drugs, and in general infectious diseases.

The RESIONS *are safe* because they are totally insoluble and non-toxic.

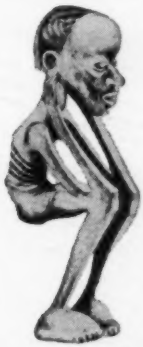
RESION therapy will control about 90% of common diarrheas.

RESION P-M-S is intended specifically for rapid control of those rare diarrheas caused by Gram-negative organisms; to prevent secondary bacterial infection; in mycotic diarrhea following the use of the broad-spectrum antibiotics, and to inhibit the enteric growth of *C. albicans* (Monilia).

Resion

time-tested, adsorbent effectiveness

Polyamine methylene resin	10%
Sodium aluminum silicate	10%
Magnesium aluminum silicate	1.25%



CONGO MAGIC
(Dysentery Fetish)

RESION *therapy now works scientific magic against diarrhea.*

and

Resion P-M-S

A new formula providing antibacterials to combat bacillary and fungal vectors

NATIONAL

Each 15 cc. contains the RESION formula plus:

Polymyxin-B sulfate	125,000 units
Phthalylsulfacetamide	1.0 Gm.
Para hydroxybenzoic acid esters	0.235 Gm.

Dosage: RESION—1 tablespoonful hourly for 4 doses; then every 3 hours while awake. RESION P-M-S—1 tablespoonful hourly for 3 doses; then 3 times daily.

Supplied: RESION, in bottles of 4 and 12 fluid ounces. RESION P-M-S, bottles of 4 fl.oz.

THE NATIONAL DRUG COMPANY
Philadelphia 44, Pa.

MAY WE SUGGEST:

When DIARRHEA proves recalcitrant to treatment, try

DONNAGEL®

(Donnatal with Kaolin and Pectin Compound)

Robins

all ages... in all seasons...

Donnagel is building an extraordinary record of clinical success, even in stubborn cases, whether organic, functional or "emotional".

Its unique formula comprehensively embraces the gastrointestinal adsorbents and detoxicants kaolin and pectin, with the proven spasmolytic-sedative properties of 'Donnatal', and the superior antacid action of dihydroxy aluminum aminoacetate... in a highly palatable suspension.

Each 30 cc. of Donnagel contains:

Hyoscyamine Sulfate	0.1037	mg.
Atropine Sulfate	0.0194	mg.
Hyoscyamine Hydrobromide	0.0065	mg.
Phenobarbital (¼ gr.)	16.2	mg.
Kaolin (90 gr.)	6.0	Gm.
Pectin (2 gr.)	130.0	mg.
Dihydroxy aluminum aminoacetate (7½ gr.)	0.5	Gm.

A. H. ROBINS CO., INC. · RICHMOND 20, VIRGINIA

Ethical Pharmaceuticals of Merit since 1878

complete
2-a day
therapy for
the anemias

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2 IBEROL FILMTABS SUPPLY:

the right amount of iron

Elemental Iron .....210 mg.
(as Ferrous Sulfate)

+

anti-pernicious anemia activity

BEVIDORAL® ..1 U.S.P. Oral Unit
(Vitamin B_{12} with Intrinsic Factor Concentrate, Abbott)

+

essential nutritional factors

Folic Acid	2 mg.
Ascorbic Acid	150 mg.
Liver Fraction 2, N.F.	200 mg.
Thiamine Mononitrate	6 mg.
Riboflavin	6 mg.
Nicotinamide	30 mg.
Pyridoxine Hydrochloride	3 mg.
Pantothenic Acid	6 mg.

Abbott

In bottles of 100, 500 and 1,000 *Filmtabs.*

FOR YOUR CARE OF OBESITY... HERE'S

"WILL POWER IN A CAN!"

That's how Dietene Reducing Supplement was described recently by a Philadelphia doctor . . . and that's exactly what it is to your obese patients. Here's why:

DIETENE solves the uncomfortable problem of between-meal hunger. Two Dietene Milk Shakes daily supply 36 grams of protein, fortified with essential vitamins and minerals. Thus, through sound nutrition alone, DIETENE satisfies both body hunger and the psychological craving for "something good to eat". With the between-meal hunger problem licked, patients find it easier to accept the reduced portions of interesting foods featured in the Dietene 1000 Calorie Diet.

DIETENE contains no drugs. It is normally safe even for cardiacs and hypertensives. It tastes good, mixes easily with milk and is economical. DIETENE *assures patient cooperation.*

TRY THE DIETENE DIET
. . . based on DIETENE, *the original Reducing Supplement—regularly succeeds where other reducing regimes fail. Free diet sheet service.*

FREE 1 LB. CAN! MAIL COUPON TODAY!

A product of

THE DIETENE COMPANY

MINNEAPOLIS 8, MINNESOTA

DIETENE is available at all drug stores in plain or chocolate flavors. 1 lb. ($1.50) is full 8-day supply.

THE DIETENE COMPANY
3017 Fourth Ave. So., Minneapolis 8, Minn.

I would like to examine the Dietene Diet based on Dietene Reducing Supplement. Please send diet sheets and a FREE one pound can of DIETENE.

Name_____ MD

Address_____

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Because of customs regulations, offer limited to U. S. only.

THORAZINE*

to relieve

"Patients who complained of 'nervousness', tension, vague feelings of unrest, and similar indicators of the presence of freely floating anxiety generally responded well to ['Thorazine']." 'Thorazine' "reduced the level of emotional tension with little loss of efficiency. In addition, by virtue of its complex pharmacodynamic effects, there was diminution of many distressing autonomic symptoms."

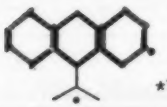
Cohen, I.M.: Am. J.M. Sc. 229:355 (April) 1955.

'Thorazine' Hydrochloride is available in 10 mg., 25 mg., 50 mg. and 100 mg. tablets; 25 mg. (1 cc.) and 50 mg. (2 cc.) ampuls; and syrup (10 mg./5 cc.).

Additional information on 'Thorazine' is available on request.

Smith, Kline & French Laboratories

1530 Spring Garden Street, Philadelphia 1



★T.M. Reg. U.S. Pat. Off. for S.K.F.'s brand of chlorpromazine.

Letters

He took out his own 'appendix' • Hackneyed emergency pleas • Surgeon Sauerbruch • Comments on malpractice insurance • Medicine's bad press

On Delegating Work

SIRS: I'm writing to protest Dr. Robert W. Johnson's "'I'm *Against* Delegating Work.'" I don't dispute his point that medical work should be performed by those who are qualified. But he could have made the point without adopting a derogatory tone toward medical aides.

Most aides are interested primarily in the welfare of the patient rather than in the exploitation of their employers. Surely a harmonious and well-run office is the product of mutual respect, as well as of proper delegation of responsibility.

Virginia Von Gunden
San Diego, Calif.

SIRS: Like Dr. Johnson, I'm against delegating work. In fact, I wouldn't even *hire* an office girl until my net income went above $12,000 a year, until my office was fully mechanized, and until I had made every possible effort to save time and mental strain by streamlining my business and professional work.

Over a period of ten years, an aide's salary may amount to $40,000 or so. But it costs only $2,000 to $4,000 to modernize the average medical office. Do it yourself—and save $38,000.

E. J. Holland, M.D.
Chicago, Ill.

'Anxiety Neurosis'

SIRS: In the article, "My Patient Just Died," a physician using the pseudonym Ambrose B. Karter tells of a case in which the patient died because he didn't return for a recommended follow-up. Dr. Karter blames himself for not making sure that the patient came back. In fact, he says, "I have been asking myself whether my name should not be written on . . . the line that is captioned 'Cause of death.'"

This doctor wants to carry the whole world on his shoulders. He'd probably derive great benefit from formal psychotherapy to get rid of his anxiety neurosis.

William R. Bunge, M.D.
Laurel, Md.

Needless Operations

SIRS: Your recent article, "Are Surgical Fees Too High?", quotes an investigator for the American Col-

for "hot-weather pruritus"

EURAX® lotion

(crotamiton GEIGY)

The problem of summertime skin lesions is essentially one of intolerable itching.

EURAX provides an answer—immediate relief of itch in more than 90 per cent of patients.

sunburn · insect bites · heat rash · poison ivy

Moreover, the effect of a single application *lasts* for 6 to 10 hours or more, permitting uninterrupted sleep throughout the night.

Colorless, greaseless and nonstaining, EURAX is invisible following application—especially important when "summer pruritus" affects exposed parts of the body.

EURAX® (brand of crotamiton) Lotion is available in 2 oz. prescription bottles, and larger size dispensing bottles. Also available—EURAX Cream in tubes of 20 Gm. and 60 Gm., and 1 lb. dispensing jars.

GEIGY PHARMACEUTICALS

Division of Geigy Chemical Corporation, 220 Church Street, New York 13, N.Y. *In Canada:* Geigy Pharmaceuticals, Montreal

61755

lege of Surgeons as calling unnecessary surgery "the greatest problem facing American medicine."

I agree. And it's not only the surgeons who are to blame. In some ten years of general practice, I have come to the conclusion that many G.P.s are doing entirely too much surgery.

Why do they do it? There are four principal reasons:

1. They want to increase their incomes.

2. They're not sure of the true cause of, and cure for, the patient's illness.

3. They feel they have to operate, in order to satisfy the patient or his family.

4. They habitually think in terms of surgery rather than of other types of therapy.

The best way to stop unnecessary surgery is to require that all surgical specimens be examined by a competent pathologist. In addition, every hospital should keep full records, including the pre- and post-operative diagnosis and a summary of the operation itself.

M.D., Tennessee

Morals Charge

SIRS: I want to express my appreciation for your journal, with its many helpful features. At the same time, I'd like to protest against such cartoons as the one I'm enclosing [see cut]. Our profession, whose goal is the restoration of health and the uplift of humanity, should be free of anything bordering on the vulgar and obscene. I hate to think that my fellow practitioners derive pleasure from such things.

Marjorie Jacobs, M.D.
Wildwood, Ga.

Cartoonist Ton Smits assures us that the doctor in his drawing is motivated by factors that are entirely commendable: a keen artistic sense and an equally keen sense of thrift (he's obviously saving a model's fee). —ED.

Razor Appendectomy

SIRS: A recent news item in your magazine quoted excerpts from an article called "You Can Take Out Your Own Appendix," which was written by Jim Comstock, editor of the Richmond (W.Va.) News Leader.

Obviously, Mr. Comstock's article was just a gag; but I'll make you an even bet that someone will be foolish enough to try to follow his instructions. In fact, here's a case in

which something of the sort actually happened:

On April 22, 1930, a New York City resident named Louis Capetta tried to operate on himself for what his friends had diagnosed as appendicitis (he really had a hernia). Using a razor, he cut into his abdomen, but abandoned the attempt, evidently because of pain. He sewed himself up with ordinary thread; the wound healed, but his symptoms persisted.

So a couple of weeks later he tried again, cutting through all the walls of the abdomen and chopping off the gut as it protruded through the wound, thinking it was the appendix. A few hours later, he was sent to the hospital, where he died, apparently of peritonitis.

George B. Kuite, M.D.
Morris Plains, N.J.

Fake Emergencies

SIRS: As the wife of a police officer, I'd like to add a brief comment to your article, "How Good a Driver Are You?":

The average traffic officer would be a lot more understanding if doctors reserved their emergency pleas for real emergencies. Such hackneyed excuses are often no more than an insult to the officer's intelligence.

As my husband recently put it, "If every OB man I've stopped was

really rushing the stork, the published figures on the birth rate are only a fraction of what they should be!"

R.N., California

'Master Surgeon' Hit

SIRS: I read with horror your article about the late Dr. Ferdinand Sauerbruch. Physicians the world over have united in condemning the atrocious medical experiments of the Nazi criminals. Yet, only a decade later, we presumably have forgotten so much that we can be amused by the light-hearted memoirs of one of the directors and guides of those very experiments.

In his book, Dr. Sauerbruch apparently claimed that the only reason for his denazification trial was that Hitler had given him an empty title and a stipend. But the report of the first military tribunal at Nuremberg shows there were other, more serious reasons:

Dr. Sauerbruch actively participated in discussions—and gave suggestions—on the use of sulfonamides in the treatment of *healthy* prisoners who served as involuntary experimental animals. They had pus injected intravenously, were given artificially induced cellulitis, and suffered deliberately untreated, unnecessary amputations. Sauerbruch found no fault with such experiments (which, tragically enough, added nothing to the sum of human knowledge).

Eminence as a surgeon does not

for
those

"on the mend"

specify

VITERRA®
THERAPEUTIC

Therapeutic formula
11 minerals, 9 vitamins—
for prompt nutritional
recovery following
illness. All in one soft
gelatin capsule.

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Supplemental formula
11 minerals, 10 vitamins—
ideal as the prophylactic
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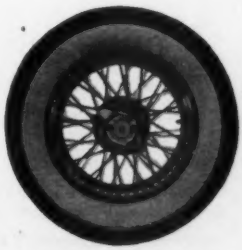
All in one soft gelatin capsule.



balanced formulae: for balanced nutrition ROERIG Rx *Chicago 11, Illinois*

condone inhumanity. Dr. Sauerbruch should be condemned as a contemptible specimen of what a doctor should not be.

Leonard Tushnet, M.D.
Maplewood, N.J.

Malpractice Insurance

SIRS: "What's Your Best Buy in Malpractice Insurance?" [MEDICAL ECONOMICS, May, 1955] is a beautifully documented article. Every doctor in America should read it.

Many suits against physicians in Oklahoma these days are charging *technical assault* rather than malpractice. Your article cited one such case: that of an Oklahoman who suffered partial paralysis following spinal anesthesia. This woman sued for technical assault because her consent to the specific type of anesthetic used had not been obtained. And she won a judgment of $60,000, plus $13,000 in interest. Other courts have used this decision as a precedent.

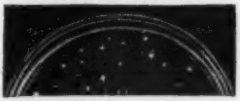
The result is that many attorneys now base their cases on similar grounds. They allege either that the doctor failed to secure consent for his method of treatment (or diagnosis) or that he employed procedures contrary to the patient's wishes.

If this tendency were carried to an extreme, the doctor might be liable to charges of assault if he failed to secure the patient's approv-

4 ways in which Hexachlorophene in

DIAL SOAP protects you and your patients

Photomicros show how Dial reduces Skin Bacteria



With ordinary soap, the most thorough washing leaves thousands of bacteria on the skin.

With Dial, with Hexachlorophene, daily use removes up to 95% of skin bacteria.

1. *Reduces chance of infection* following abrasions, scratches, for Dial effectively reduces skin bacteria count.

2. *Stops perspiratory odor* by preventing bacterial decomposition of perspiration, known as the chief cause of odor.

3. *Protects infants' skin,* helps prevent impetigo, diaper and heat rash, raw buttocks; stops nursery odor of diapers.

4. *Helps skin disorders* by destroying bacteria that often spread and aggravate pimples, surface blemishes.

You are no doubt familiar with the remarkable antiseptic qualities of Hexachlorophene soaps, as documented in recent literature. Dial was the first Hexachlorophene soap offered to the public.

You can safely recommend Dial. Under normal conditions it is non-toxic, non-irritating, non-sensitizing. Economically priced, Dial is widely available to patients everywhere.

Free to doctors!

As the leading producer of such soaps, we offer you a "Summary of Literature on Hexachlorophene Soaps in the Surgical Scrub." Send for your free copy today.

From the laboratories of Armour and Company

ARMOUR AND COMPANY
1355 W. 31st STREET
CHICAGO 9, ILLINOIS

Name.....

Street.....

City..... Zone..... State .....

al for even the most trifling service. Certainly, court decisions have failed to bear out the theory that the doctor knows what's best for his patient. Instead, they seem to recognize the patient's right to dictate procedure.

In the opinion of our local malpractice insurance committee, this is a most serious problem, with tremendous ramifications . . .

Jack Spears
Executive Secretary
Tulsa County Medical Society
Tulsa, Okla.

SINS: . . . I discussed this article with a colleague who has had extensive experience on a malpractice committee. He commented that malpractice suits are usually based on resentment against the physician. Often, he added, such resentment arises because the doctor failed to prepare the patient psychologically for possible unsatisfactory results . . .

William H. Halley, M.D.
Denver, Colo.

SINS: I want to compliment you on a superb job . . .

It might be said that the commotion over malpractice insurance has been noisier than it need be. For instance, it is true, as your article mentioned, that Aetna withdrew from group operation with Connecticut doctors in 1952, after about twenty-five years of mutually satisfactory experience. We didn't like that, of course. But calm thinking brought us to the conclusion that if

the company had to insure all members of our society—even the ones with bad liability experience—this made the insurance overly expensive for the doctor with *good* experience.

Then Aetna embarked on its tie-in sales project that caused a good deal of disturbance. I'm pleased to say, though, that after gentlemanly negotiations they gave up the idea. Aetna's agents are encouraged to seek profitable lines of business from Connecticut physicians; but the doctors aren't *required* to buy other types of insurance from the company in order to get malpractice coverage.

Our premiums are now perhaps twice what they were when I started in practice thirty-five years ago. (But what hasn't gone up in that period?) And surgeons are charged 50 per cent more than most other doctors. This is a fair arrangement, since the surgeon's risk is at least that much greater . . .

So the "crisis" in Connecticut is over—for the present, anyway.

Creighton Barker, M.D.
Executive Secretary
Connecticut State Medical Society
New Haven, Conn.

SIRS: The incidence of malpractice claims continues to rise in most of the metropolitan areas across the country. The only exception is in the few localities where sound and efficient malpractice prevention and educational programs have been carried out.

A sound preventive program—

HANDICAPS
... OR
REVICAPS?

REVICAPS*

d-Amphetamine—Vitamins and Minerals Lederle

***RE**ducing*
***VI**tamin*
***CAPS**ules*

REVICAPS are an aid in solving the problems of weight reduction. They help the patient to follow a restricted diet. Simultaneously they provide all essential vitamins and minerals.

The methylcellulose content (200 mg.) provides bulk and the inclusion of 5 mg. of d-Amphetamine Sulfate suppresses appetite and elevates the mood of the patient—thereby improving his cooperation.

BOTTLES of 100 and 1,000. Available *only on your prescription.*

DOSAGE: One or two capsules, ½ to 1 hour before each meal.

Lederle

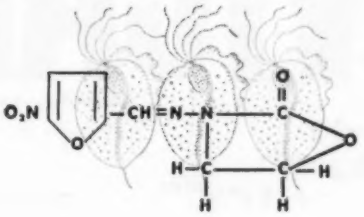
LEDERLE LABORATORIES DIVISION
AMERICAN Cyanamid COMPANY
PEARL RIVER, NEW YORK

*REG. U.S. PAT. OFF.

Now...a new and specific drug for t

Tricofuron contains Furoxone® (brand of furazolidone), an antimicrobial nitrofuran specific against Trichomonas vaginalis. More than 300 nitrofurans were screened before discovery of this potent new trichomonacide.

- Rapid relief of symptoms, usually in 2 or 3 days.
- Cures in 1 menstrual cycle.
- Low incidence of recurrence as proved by repeated microscopic examinations.
- Bactericidal against a wide range of gram-positive and gram-negative organisms.



Tricofuron Vaginal Suppositories contain Furoxone 0.25% in a water miscible base, hermetically sealed. Box of 12.

Tricofuron Vaginal Powder contains Furoxone 0.1% in a water soluble powder base composed of lactose, dextrose and citric acid. Bottle of 30 Gm.

Both dosage forms are used concomitantly.

for trichomonal vaginitis...

Tricofuron™

VAGINAL SUPPOSITORIES AND POWDER

*Proof of excellent clinical results with Tricofuron therapy.**

124 CASES

84.7%	Cures (105 cases)
9.7%	Symptomatic Improvement Only (12 cases)
5.6%	Failures (7 cases)

*Adapted from scientific exhibit at Annual Meeting of the American Medical Association, 1955.

A full product report and patient instruction folders available on request.

EATON LABORATORIES
NORWICH • NEW YORK

THE NITROFURANS—A UNIQUE CLASS OF ANTIMICROBIALS O_2N PRODUCTS OF EATON RESEARCH

whether conducted by the doctors themselves or by an enlightened insurance carrier—cannot function effectively unless it is guided and directed by a medicolegal expert who is qualified in this specialized field.

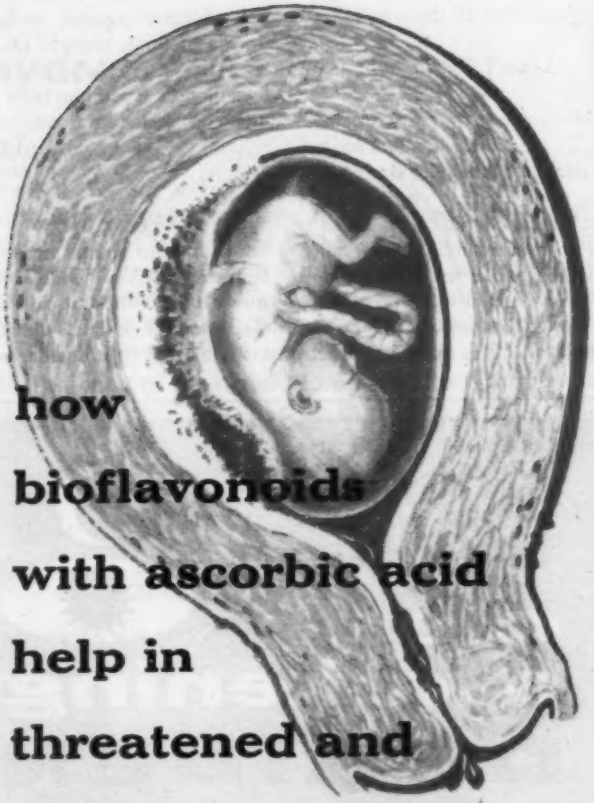
Louis J. Regan, M.D., LL.B.
Los Angeles, Calif.

SIRS: . . . Too many doctors are uneducated as to their legal responsibility; they have no concrete idea about how to conduct themselves in order to prevent malpractice suits. I'm willing to bet that if the nation's M.D.s were given a comprehensive test along this line, 95 per cent would flunk . . . To such men, I recommend a careful study of Dr. Louis J. Regan's excellent book, "Doctor and Patient and the Law."

Another thing: Many, many physicians overlook the fact that the best defense against malpractice suits is adequate records. Dr. Regan cites case after case where the doctor's records saved him from a judgment.

Millard K. Mills
Professional Management
Waterloo, Iowa

SIRS: In your recent article, "How Britons Get Cheap Malpractice Insurance," Edwin N. Perrin describes the workings of M.D.-cooperatives to insure and fight against malprac-



how bioflavonoids with ascorbic acid help in threatened and habitual abortion...

Frequent nosebleeds, gum bleeding and easy bruising were observed in a high percentage of women who had repeated abortions, according to one study.[1]

Another investigator[2] reported abnormal capillary fragility in 80% of habitual aborters.

C.V.P. helps to diminish abnormal capillary permeability and fragility by acting to maintain the integrity of the "cement" substance of capillary walls. Thus, C.V.P. may be a helpful adjunct in the management of threatened and habitual abortion.

C.V.P. provides the capillary-protectant factors of whole citrus bioflavonoid compound (sometimes referred to as "vitamin P complex"), combined with ascorbic acid. C.V.P. is water-soluble and believed to be more readily absorbed than relatively insoluble rutin.

CVP®

Each C.V.P. capsule or teaspoonful (5 cc.) of syrup provides:

Citrus Flavonoid Compound . . 100 mg.
Ascorbic Acid (vitamin C) . . . 100 mg.

rationale: The correction of abnormal capillary fragility in habitual aborters supposedly "decreases the possibility of retroplacental hemorrhage, or possibly enhances the efficacy of established therapeutic regimens by modifying capillary permeability and vascular disturbances throughout the body, whether they be in the skin, liver or the placenta."[2]

Bottles of 50, 100, 500 and 1000 capsules; 4 oz., 16 oz. and gallon syrup.

1. Science News Letter, March 1954
2. Greenblatt, R. B.: Obstet. & Gyn. 2:530, 1953

samples and literature from **u. s. vitamin corporation**
(Arlington-Funk Laboratories, division)
250 East 43rd Street, New York 17, N.Y.

tice suits in Great Britain. He also discusses the possibility of setting up similar medical defense societies in the U.S.

The author appears to be unaware that, as long as forty years ago, many state medical societies in this country did have defense funds, with legal machinery similar to that of the English cooperatives. But the societies got into trouble, since this system destroyed the backbone of the doctor's defense—namely, expert testimony untainted by any suspicion of bias. And they ran into Federal tax complications in trying to operate as insurance organizations without meeting the necessary tax impositions.

Most such defense funds have now been discontinued; but a few, I believe, still exist.

Insurance Executive, Indiana

Bad Press

SINS: Much of medicine's poor press can be traced directly to irresponsible members of the profession. For instance, a "Doctor Wanted" ad that an M.D. placed recently in a New Orleans newspaper—and presumably others—concluded with the words: "Addicts need not apply."

If wording like this is justifiable at all, it should be restricted to a professional journal.

Richard M. Dawes, M.D.
Thibodaux, La.

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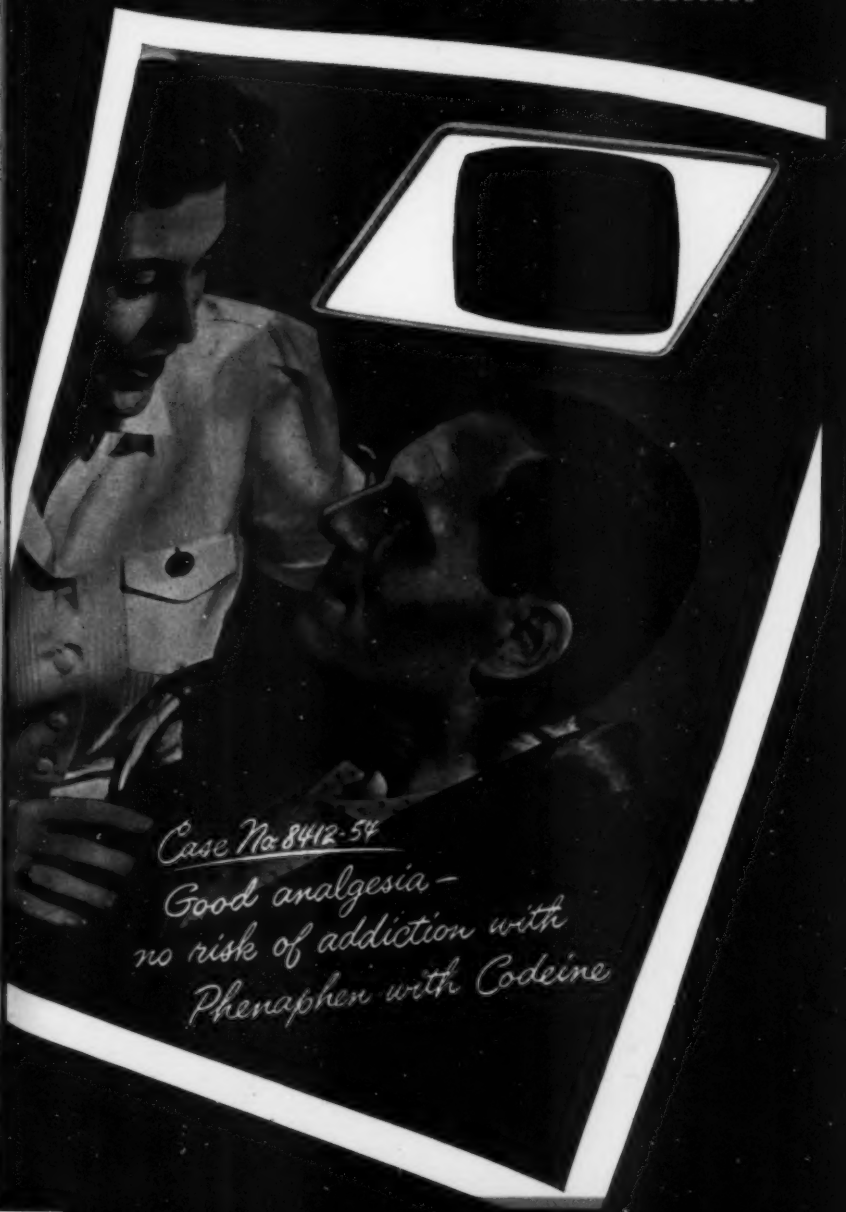
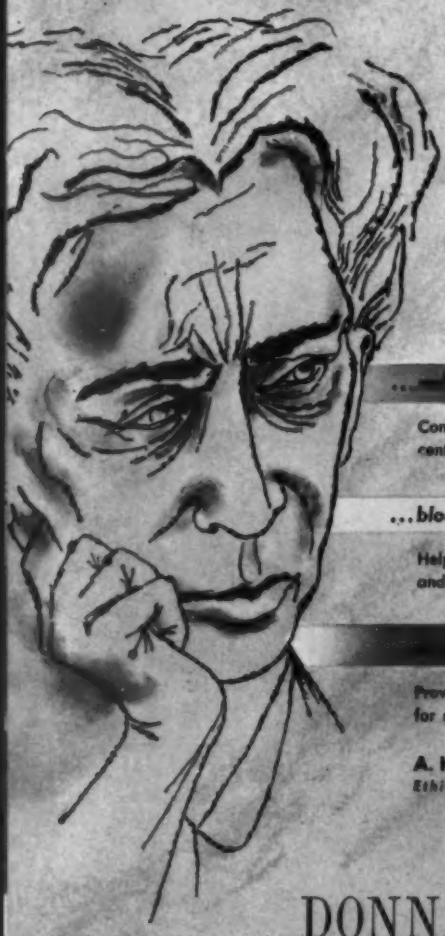



Maximum safe an
even in severe pain...
By the synergism of codeine phosphate with the ingredients of the Phenaphen formula, analgesic action is so enhanced that even the pain of late cancer is satisfactorily controlled in many cases. This maximum *safe* analgesia avoids the addiction hazard of morphine or of synthetic narcotics.
PHENAPHEN®
with CODEINE
Robins
A. H. Robins Co., Inc., Richmond 20, Va.
Ethical Pharmaceuticals of Merit since 1878


afe analgesia–
the prescription behind the clinical success
Rx
Four analgesic potencies to meet individual requirements
PHENAPHEN®
(basic non-narcotic formula)
Acetylsalicylic acid 162 mg. (2½ gr.)
Phenacetin ..... 194 mg. (3 gr.)
Phenobarbital ..... 16.2 mg. (¼ gr.)
Hyoscyamine sulfate 0.031 mg. 1/2000 gr.
(Brown and white capsules)
PHENAPHEN® with CODEINE PHOSPHATE
½ GR. (16.2 mg.)
(PHENAPHEN NO. 2)
(Black and yellow capsules)
PHENAPHEN® with CODEINE PHOSPHATE
½ GR. (32.4 mg.)
(PHENAPHEN NO. 3)
(Black and green capsules)
PHENAPHEN® with CODEINE PHOSPHATE
1 GR. (64.8 mg.)
(PHENAPHEN NO. 4)
(Green and white capsules)
new



FOR THE CHRONIC FATIGUE SYNDROME

Donnatal Plus

provides triple action

...[illegible]

Controls cerebrogenic overactivation of autonomic centers by mild sedation.

...blocks parasympathetic over-stimulation

Helps prevent hyperinsulinism and hypoglycemia, and protects alimentary tract from hypermotility.

Provides important B-complex vitamins essential for normal carbohydrate metabolism.

A. H. ROBINS CO., INC. · Richmond 20, Va.
Ethical Pharmaceuticals of Merit since 1878

DONNATAL® PLUS

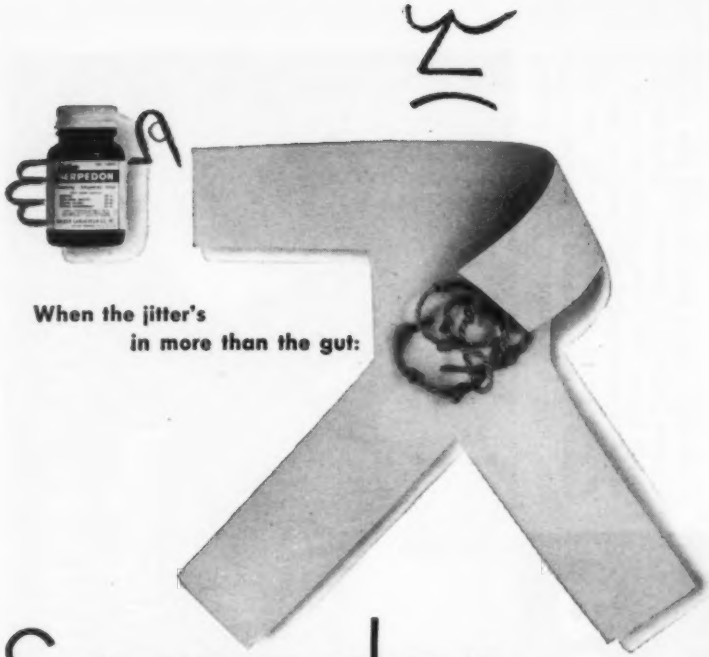
Robins

(Donnatal with B Complex)

Each Tablet or 5 cc. teaspoonful of Elixir provides:

Hyoscyamine sulfate .....0.1037 mg.	Riboflavin .....2.0 mg.
Atropine sulfate .....0.0194 mg.	Nicotinamide .....10.0 mg.
Hyoscine hydrobromide 0.0065 mg.	Pantothenic acid .....2.0 mg.
Phenobarbital (¼ gr.) .....16.2 mg.	Pyridoxine hydrochloride ....0.5 mg.
Thiamine .....2.0 mg.	

500 cc. and 1000 cc.



Serpedon

the tension-easing antispasmodic

Serpedon* helps you treat the jittery patient with the jittery gut, not just his spasm, which is most likely a symptom of his real trouble: anxiety and tension. Serpedon is 0.1 mg. reserpine, plus three alkaloids of belladonna, equivalent to 7 minims of the tincture. Serpedon rescues the patient from his symptom-producing anxiety and tension with reserpine . . . tranquilizes him, doesn't dull him. Serpedon stops spasm . . . stops it quickly, gives reserpine time to exert its full, tension-easing effect. Recommended dose is one tablet t.i.d. Supplied in bottles of 100 scored tablets. *trademark

Walker Laboratories, Inc., Mount Vernon, New York

for dramatic results in hay fever

During the ragweed season . . . HP*ACTHAR *Gel* provides your patients with powerful protection against allergic manifestations of hay fever. It is equally effective in the young and the aged.

HP*ACTHAR® *Gel* is The Armour Laboratories Brand of Purified Adrenocorticotropic Hormone—Corticotropin—ACTH.

In potencies of 40 and 80 Armour Units per cc., in 5 cc. vials.

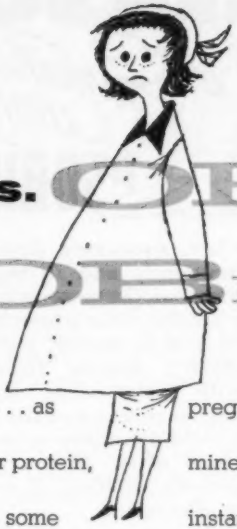
HP*ACTHAR *Gel*
(IN GELATIN)

- **small doses**
  Hay fever sufferers get striking relief of symptoms from even small doses of HP*ACTHAR *Gel.*

- **short-term therapy**
  In hay fever, HP*ACTHAR *Gel* need be given only for a short time. It is administered as easily as insulin. Discomfort is minimal.

*Highly Purified

THE ARMOUR LABORATORIES
A DIVISION OF ARMOUR AND COMPANY • KANKAKEE, ILLINOIS



Mrs. OB needs an OBRON buildup

"... as pregnancy advances the requirements for protein, minerals and vitamins are increased in some instances one hundred per cent."[1]

OBron supplies iron and calcium plus eight other minerals, eight essential vitamins.

The OBron Buildup: A basic nutritional buildup for your OB patients, one to three capsules daily. Bottles of 30 and 100 soft, soluble capsules.

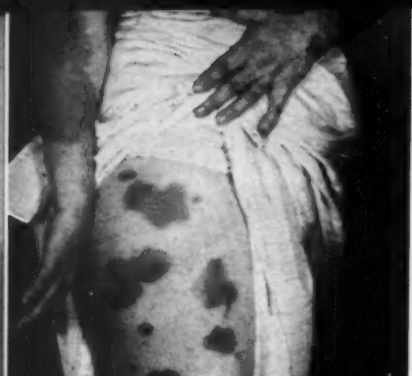
ROERIG CHICAGO 11, ILLINOIS

ALL IN ONE CAPSULE

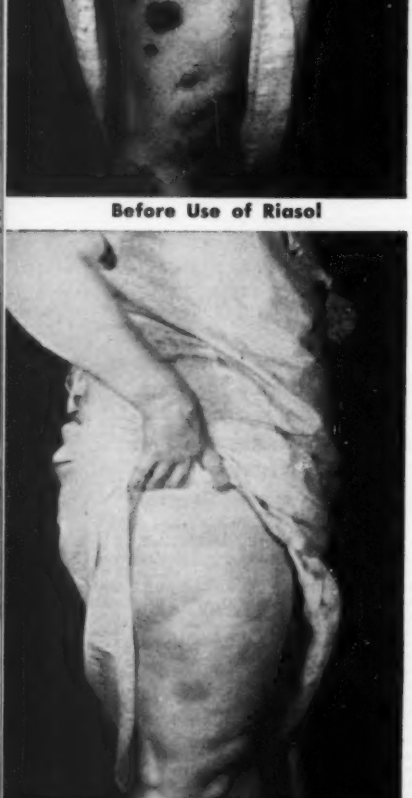
Dicalcium Phosphate Anhydrous*	770 mg.
Ferrous Sulfate Dried, U.S.P.	44 mg.
Vitamin A (Palmitate)	5,000 U.S.P. Units
Vitamin D (Irradiated Ergosterol)	400 U.S.P. Units
Thiamine Hydrochloride, U.S.P.	2 mg.
Riboflavin, U.S.P.	2 mg.
Pyridoxine Hydrochloride, U.S.P.	0.5 mg.
Ascorbic Acid, U.S.P.	37.5 mg.
Niacinamide	20 mg.
Calcium Pantothenate	3 mg.
Cobalt (from Cobaltous Sulfate)	0.033 mg.
Copper (from Cupric Sulfate)	0.33 mg.
Iodine (from Potassium Iodide)	0.05 mg.
Manganese (from Manganese Sulfate)	0.33 mg.
Magnesium (from Magnesium Sulfate)	1 mg.
Molybdenum (from Sodium Molybdate)	0.07 mg.
Potassium (from Potassium Sulfate)	1.7 mg.
Zinc (from Zinc Sulfate)	0.4 mg.

*Equivalent to 975 mg. Dicalcium Phosphate Dihydrate.

1. Burke, B. S. and Stuart, H. D.: Nutrition requirements during pregnancy and lactation. J.A.M.A. 132:119 (May 8) 1948.



Before Use of Riasol



After Use of Riasol

RIASOL

for Summer Comfort in PSORIASIS

The hot, sweltering days of sum mer frequently add to the genera discomfort of the psoriasis sufferer At this season your prescription fo RIASOL will be doubly welcome.

RIASOL'S unique formula ha met with outstanding success i psoriasis. In most cases the unsightl lesions yield promptly to its effectiv action and often do not recur fo long periods. Itching, if present, i usually alleviated.

Even the most fastidious patien welcomes RIASOL. It is simple an easy to apply, does not stain and n bandages are required.

RIASOL contains 0.45% mercur chemically combined with soap 0.5% phenol and 0.75% cresol in washable, non-staining, odorless ve hicle.

Apply daily after a mild soap bat and thorough drying. A thin, invi ible, economical film suffices. Afte one week, adjust to patient's progres

RIASOL is supplied in 4 and 8 fld. o bottles at pharmacies or direct.

MAIL COUPON TODAY—
TEST RIASOL YOURSELF

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SHIELD LABORATORIES
12850 Mansfield Ave.,
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Please send me professional literature and generous clinical package of RIASOL.

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RIASOL FOR PSORIASIS

the Fleet Enema

Disposable Unit

for routine
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special purpose
enemas

Simplifies
pre-proctoscopy
preparation

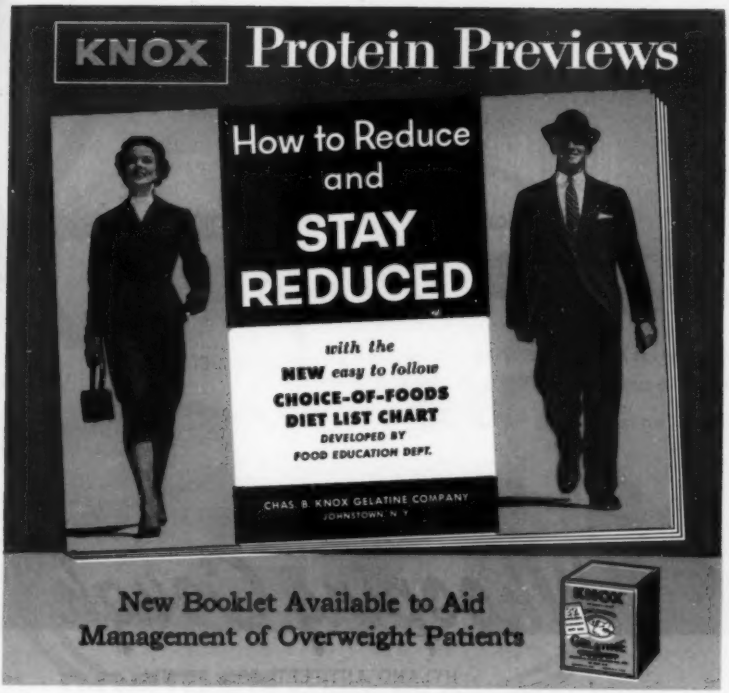
- **Superior in cleansing effect** to a tap water, or saline enema of one or two pints . . . and less irritating than a soap-suds enema.
- **Rapid** — with the FLEET ENEMA Disposable Unit, the entire procedure can be completed in ¼ the time required with older more cumbersome methods.
- **Prompt and thorough evacuation** . . . a time-saving factor, particularly in preparation for examination.
- **Comfort to patient assured** . . . virtually no distention or side effects.

And in addition: "Squeeze bottle" permits one hand administration . . . distinctive rubber diaphragm controls flow while preventing leakage . . . rectal tube enclosed in sealed cellophane envelope, sanitary to time of use . . . readily disposable.

Each 4½ Fl. Oz. Fleet Enema Disposable Unit contains in each 100 cc., 16 Gm. sodium biphosphate and 6 Gm. sodium phosphate . . . an enema solution of Phospho-Soda (Fleet) . . . gentle, prompt, thorough.

C. B. FLEET CO., INC.
LYNCHBURG, VIRGINIA

'Phospho-Soda', 'Fleet' and 'Fleet Enema' are registered trade-marks of C. B. Fleet Co., Inc.



The 1955 edition of the well-known Knox "Eat-and-Reduce" booklet eliminates calorie counting for your obese patients. This year's edition is based on the use of Food Exchange Lists[1] which have proved so accurate in the dietary management of diabetics. These lists have been adapted to the dietary needs of patients who must lose weight.

The first 18 pages of the new booklet present in simple terms key information on the use of Food Exchanges (referred to in the book as Choices). In the center, double gatefold pages outline color-coded diets of 1200, 1600, and 1800 calories based on the Food Exchanges. Physicians will find these diets easy to revise to meet the special needs of individual patients.

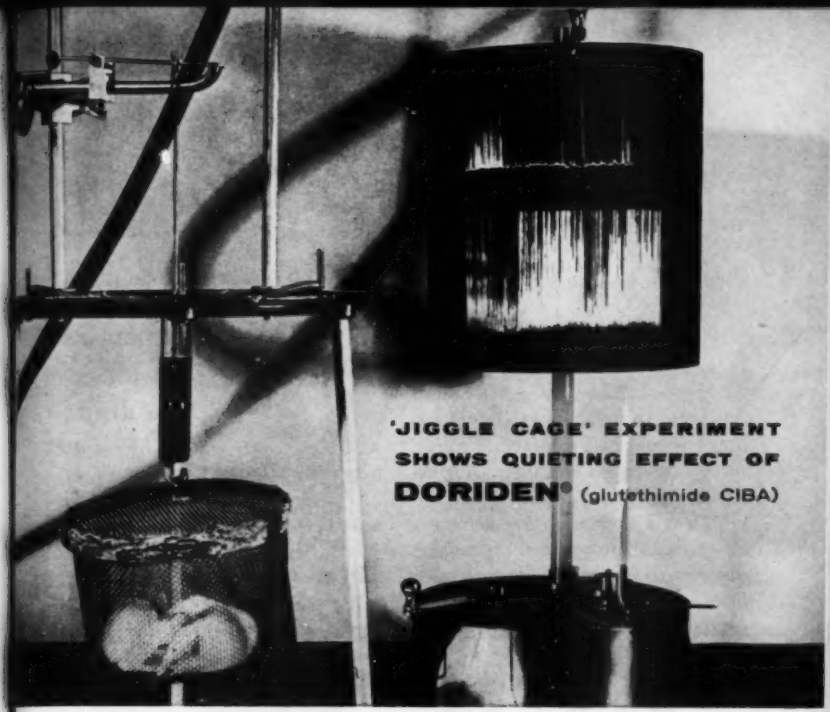
To help patients persevere in their reducing plans, the last 14 pages of the new Knox booklet are devoted to more than six dozen, *tested*, low-calorie recipes. Please use the coupon below to obtain copies of the new "Eat-and-Reduce" booklet for your practice.

1. Developed by the U. S. Public Health Service assisted by committees of The American Diabetes Association, Inc. and The American Dietetic Association.

Chas. B. Knox Gelatine Company, Inc.
Professional Service Dept. ME-8
Johnstown, N. Y.

Please send me____copies of the new illustrated Knox "Eat-and-Reduce" booklet based on Food Exchanges.

YOUR NAME AND ADDRESS



That **DORIDEN**—a totally new nonbarbiturate hypnotic and sedative—is effective as a quieting agent is demonstrated by this pneumatic movement recorder (jiggle cage), which measures the activity of laboratory animals. Note the marked change in the activity of mice after the administration of DORIDEN. Further evidence of the sedative and hypnotic effectiveness of DORIDEN is provided by numerous clinical studies. DORIDEN acts in 15 to 30 minutes and affords 4 to 8 hours of sound refreshing sleep. Present clinical evidence indicates it is not habit forming.

Tablets (white, scored), 0.25 and 0.5 Gm. C I B A SUMMIT, N. J.

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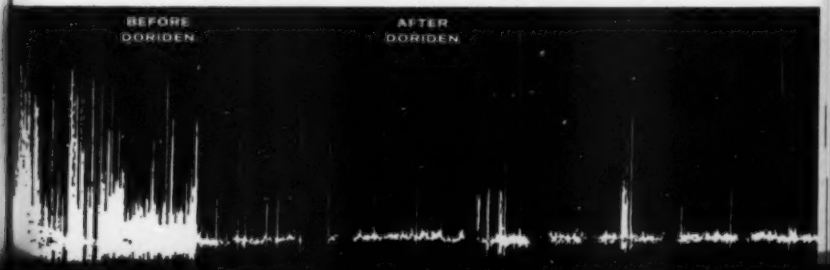


Editorials

Can you tell whether your practice is expanding as it should? • Why the osteopaths can't be counted out • One reason for the polio confusion

Growth of a Practice

How much should a practice grow each year? Two young doctors have asked us this. Their separate queries suggest some rough yardsticks that many an M.D. can use.

The first man brought up the question this way: "I'm a young internist who recently started practice in a suburb of New York City. On the basis of my earnings over the first four months, I estimate that in another three months I'll be clearing my basic personal and office expenses (about $600 a month). In other words, seven months after starting practice I expect to be a going concern. It would interest me greatly to discover if I'm about average in this respect . . ."

The second doctor put it like this: "I graduated from medical school in 1951 and, after one year's internship, started from scratch in a small Pennsylvania town that has only two other G.P.s. I've practiced here nearly three years. My volume is now just over $2,000 a month . . . Is this progress satisfactory?"

Far be it from us to suggest that there's a simple formula for gauging the growth of all medical practices. There isn't. But we *can* suggest two ways to get a line on whether your practice is coming along as it should.

One way is objective: You simply compare other doctors' experiences with your own. The two cases mentioned earlier, for example, seem rather typical of beginning practitioners nowadays. Here are three more that seem to illustrate what's normal growth—and what isn't:

¶ Following five years' graduate work in medicine, two young men became partners in a Midwestern town. They were "prepared to starve" for nine months. Actually, by the end of that period, they were grossing $2,100 a month between them.

¶ Fresh from residency, a young man went into family practice in a small Southern city. After half a year, his monthly earnings had reached $800. After a full year, they'd reached $1,200.

¶ Another Southerner—an OB man—made a poor choice of town. An older obstetrician there had the specialty pretty well sewed up. Today,

fifteen months later, the younger man hasn't passed the break-even point. His office expenses (about $450 a month) still outrun his income.

Based on these experiences and others, you can set up some fairly arbitrary rules. These provide another way—a subjective one—to check up on the growth of your practice. You can say, for example, that:

1. In your first year of practice, you should clear your professional and living expenses.

2. In your second year of practice, you should become comfortably established.

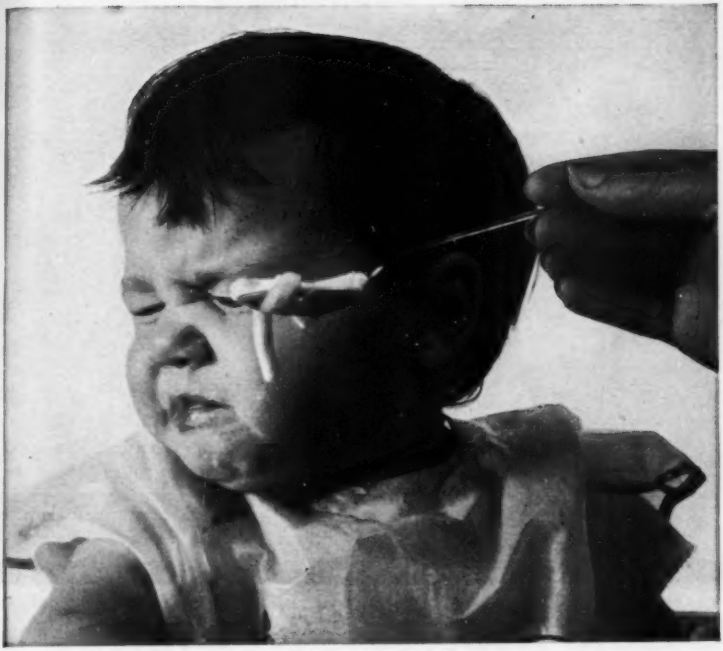
3. In your third year and thereafter, your practice should grow from 5 to 10 per cent a year.

Naturally, these rules are subject to infinite variation. Surgical specialists tend to start more slowly, then build up their practices with a greater rush. Medical men, on the other hand, may work up to an early peak and then level off.

At any rate, if your practice is growing more slowly than indicated here, better find out the reason. For steady growth seems normal. Lack of it may well signify something wrong.

They Come When Called

In spite of medical opposition, osteopaths are coming up in the world. If you wonder why, take a look at



to restore appetite and promote weight gain

LACTOFORT

FOR RELUCTANT FEEDERS

LACTOFORT
The Complete Pediatric Nutritive Supplement

the first pediatric dietary formulation to provide adequate quantities of L-lysine for optimal growth and for the stimulation of normal appetite —

PLUS *all* essential vitamins in excess of dietary allowances,

PLUS essential iron and calcium.

2 measures (2.3 Gm.) of Lactofort supply:

L-lysine (from L-lysine monohydrochloride)	500	mg.
Vitamin A acetate	3750	U.S.P. Units
Vitamin D	1000	U.S.P. Units
Thiamine mononitrate	0.75	mg.
Riboflavin	1.25	mg.
Niacinamide	7.5	mg.
Vitamin B_{12}	2.5	mcg.
Folic Acid	0.25	mg.
Ascorbic acid (from sodium ascorbate)	75	mg.
Pyridoxine hydrochloride	0.75	mg.
Calcium pantothenate	7.5	mg.
Iron ammonium citrate green (elemental iron 7.5 mg.)	50	mg.
Calcium gluconate (elemental calcium 130 mg.)	1.45	Gm.

Supplied: In 46 Gm. bottles with special Lactofort measuring spoon enclosed.

WHITE LABORATORIES, INC., **Kenilworth, N. J.**

Gastric Hyperacidity: etiology

People being people, environmental factors contributory to gastric hyperacidity are hard to remove, even when their role is clearly defined. But, the physician has a sure, simple—even pleasant—way of relieving the acid distress caused by:

- dietary indiscretion
- nervous tension
- emotional stress
- food intolerances
- excessive smoking
- alcoholic beverages

Gelusil promptly and effectively controls the excessive gastric acidity of "heartburn" and chronic indigestion. And it affords equally rapid relief in peptic ulcer. Sustained action is assured by combining magnesium trisilicate with the specially prepared aluminum hydroxide gel.

Free from constipation: Gelusil's aluminum hydroxide component is specially prepared: the concentration of aluminum ions is accordingly low; hence the formation of astringent—and constipating—aluminum chloride is minimal.

Free from acid rebound: Unlike soluble alkalies, Gelusil does not over-neutralize or alkalinize. It maintains the gastric pH in a mildly acid range—that of maximum physiologic functioning.

Dosage—2 tablets or 2 teaspoonfuls two hours after eating or when symptoms are pronounced. Each tablet or teaspoonful provides: 7½ gr. magnesium trisilicate and 4 gr. aluminum hydroxide gel.

Available—Gelusil Tablets in packages of 50, 100, 1000 and 5000. Gelusil Liquid in bottles of 6 and 12 fluidounces.

Gelusil®

Antacid • Adsorbent

WARNER-CHILCOTT

what's happening in Passaic County, N.J.:

A recurrent complaint there is, "You can't get an M.D. to answer an emergency call!" This complaint is relayed to us not by an embittered patient, but by Dr. John A. Ianacone, editor of the Passaic County Medical Society Bulletin. By contrast, Dr. Ianacone adds, the local osteopaths are "on the ball . . . willing, able, and ready to answer emergency calls anywhere, any time."

Some months ago, the medical society set up panels of medical men willing to take emergency calls. But a recent case suggests that many an M.D. does his best to duck them. As Dr. Ianacone tells it:

"At 4:30 in the morning, the physician's exchange received an emergency call while covering one of our doctors. He was called at home . . . He requested that [another] doctor be sent out . . . but he said 'No osteopath.' Eight physicians on the panel were contacted, none of whom would go. [When] the doctor was so informed . . . he said 'Send anybody.' An osteopath was called after almost an hour and a half [had been] wasted . . . He accepted, quickly and efficiently . . ."

There's nothing unique about Passaic. It's different from countless other counties throughout the U.S. only in having a medical editor frank enough to face facts—and print them. Doctors in other areas might well ponder Dr. Ianacone's conclusion:

"Have we become so preoccupied

with the business of money-making that we have lost insight? . . . The public will not [go] without medical attention because their acute illness or accident does not suit the M.D. No, not while the osteopaths are available . . .

"If each individual does his part [in responding to emergency calls], our profession . . . will again rise to its proper level in the community."

Not many people know the difference between a D.O. and an M.D. But *everyone* knows the difference between a doctor who comes when he's needed and a doctor who doesn't. Whenever we get so careless as to forget the importance of this, our "level in the community" becomes exactly what we deserve: second-best to the osteopaths.

Vaccine Vagaries

Some doctors have taken to calling it, "The Infantile Foundation for National Paralysis." This reflects their extreme dissatisfaction with the Foundation's mad rush to get the Salk vaccine into immediate use. But it doesn't reflect the whole story, as readers of Greer Williams' report in this issue will discover. If the Polio Foundation was at fault, it was by no means alone.

Consider the Laboratory of Biologics Control in the Public Health Service. This was the agency that set standards for safety, purity, and potency before any biologic could be licensed in interstate commerce. It

new product FILLS THE

THERAPEUTIC GAP IN RHEUMATIC CONDITIONS

Armyl + F

for • the patient who fails to respond to salicylates alone

• the patient who needs long-term management of residual symptoms

Each Armyl + F capsulette supplies:

Compound F (hydrocortisone-free alcohol)	2.0 mg.
Potassium Salicylate (5 gr.)	0.30 Gm.
Potassium Para-aminobenzoate (5 gr.)	0.30 Gm.
Ascorbic Acid	50.0 mg.

Bottles of 50 capsulettes

Armyl + F is a new antirheumatic and anti-inflammatory agent with analgesic effects. It gives you significant advantages of combined simultaneous action in arthritic-rheumatic disease.

• rheumatoid arthritis and spondylitis (mild and moderately severe) • osteoarthritis (when pain is due to inflammation) • rheumatic fever (subacute phase of mild degree; subclinical relapses in children) • gout—subacute and interval gout (along with purine restriction) • bursitis, myositis, tendinitis, synovitis, fibrositis, neuritis

THE ARMOUR LABORATORIES
A DIVISION OF ARMOUR AND COMPANY • KANKAKEE, ILLINOIS

fell on its face with the Salk vaccine —and, as a result, was recently reorganized into a Division of Biologics Standards under different direction.

That the Laboratory of Biologics Control missed a trick or two was courageously acknowledged by Surgeon General Leonard A. Scheele in his so-called White Paper, or June technical report, to Secretary Hobby. The trouble apparently began in March, 1954. "Soon after vaccine production for the field trial was started," said the Scheele report, "live virus was detected . . . in four out of six supposedly inactivated lots of vaccine." So the L.B.C. established more stringent processing controls, including "the requirement that a series of consecutive lots with negative tests must be produced by a manufacturer to demonstrate a consistent performance . . ."

Then, having established consistent performance as a criterion, the L.B.C. promptly forgot about it. Manufacturers were told to submit protocols (detailed written reports of the processing) only on lots submitted for release. In other words, on good batches only. The White Paper was quite specific about this regulatory oversight:

"The records which manufacturers were required to submit did not include certain data which are essential for an adequate assessment

NO ONE IS COMPLETELY IMMUNE

BONAMINE* HCl

BRAND OF MECLIZINE HYDROCHLORIDE

Motion sickness afflicts people of all ages because almost everyone is sensitive to labyrinthine irritation induced by travel on land and sea and in the air.

Bonamine has proved unusually effective to prevent and treat this minor but distressing complaint. And a new agreeable method of administration is now offered by the incorporation of this well-tolerated agent, with its prolonged action, in a pleasantly mint-flavored chewing-gum base. 90% of the drug content becomes available in only five minutes of chewing.

Bonamine is also indicated for the control of nausea, vomiting and vertigo associated with labyrinthine and vestibular disturbances, postoperative status, Menière's syndrome and radiation therapy.

Supplied:

Bonamine Tablets *(scored and tasteless) 25 mg.*

New **Bonamine Chewing Tablets** *25 mg.*

Pfizer

PFIZER LABORATORIES
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*TRADEMARK

Today's foremost antibiotic!

ACHROMY

—true broad-spectrum activity

—rapid diffusion and penetration

—prompt control of infection

—negligible side effects

—effective against Gram-positive and Gram-negative bacteria, rickettsia, spirochetes, certain viruses and protozoa

—produced under rigid quality control in Lederle's *own* laboratories

YCIN*

TETRACYCLINE *Lederle*

DOSAGE FORMS FOR EVERY NEED...A CHOICE OF POTENCIES!

New!

ACHROMYCIN SF

ACHROMYCIN WITH STRESS FORMULA VITAMINS

filled sealed capsules—a Lederle exclusive! No oil, no paste, tamper-proof. More rapidly and completely absorbed. Stress vitamin formula as suggested by the National Research Council. Prescribe ACHROMYCIN SF for prompt control of infection and rapid patient recovery, particularly in prolonged illness. *Capsules of 250 mg.*

Also available: ACHROMYCIN SF Oral Suspension: 125 mg. per teaspoonful (5 cc.), 2 oz. bottle.

Lederle

LEDERLE LABORATORIES DIVISION *AMERICAN Cyanamid COMPANY* Pearl River, N.Y.

®REG. U. S. PAT. OFF.

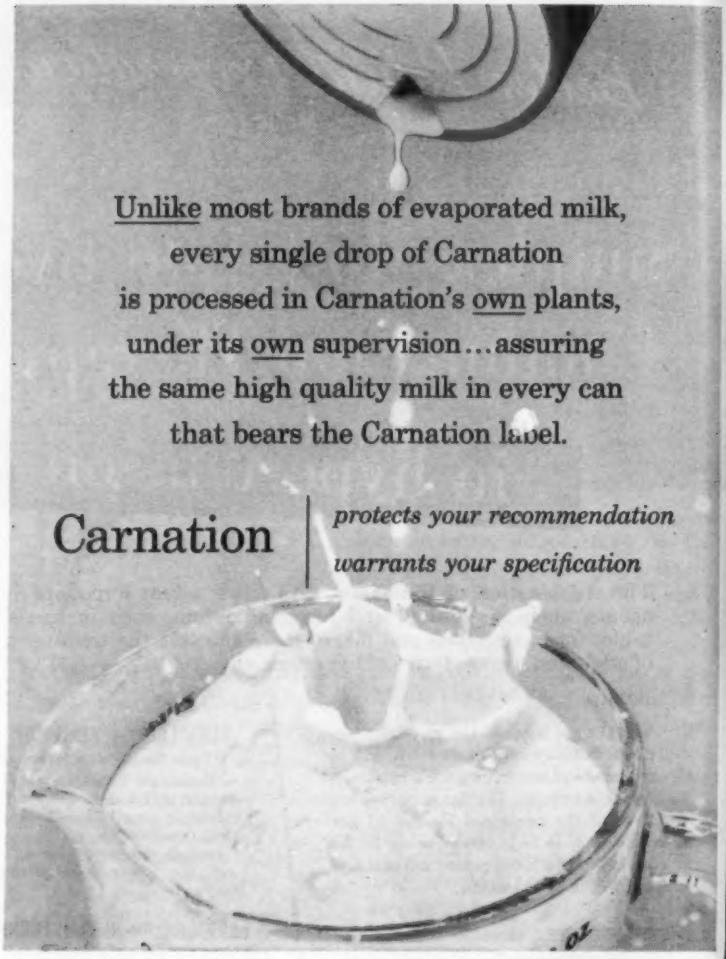
of consistency of performance. The protocols submitted . . . gave no information concerning lots discarded in the course of manufacture . . . The total experience of the manufacturers now reveals that the process of inactivation did not always follow the predicted course . . ."

Thus the L.B.C.—the one agency in a position to discover defects in the processes laid out for manufacturers—didn't really look for them. And it relaxed even further following the April 12 announcement of the field trial's success. The vaccine used in the field trial had undergone "triplicate testing" (meaning that small volumes of each lot had been tested by the manufacturer, by Dr. Salk's laboratory, and by the L.B.C.). Come April 12, the L.B.C. released some lots after one test only—the manufacturer's.

Why? The reason given in the White Paper is a *non sequitur:* "The field trial evidence itself was interpreted to indicate that the commercial product was safe." And the field trial, we have just noted, was made with triple-tested vaccine!

In view of this erratic performance, we think Dr. Scheele was wise in reorganizing the L.B.C. And we think doctors in general were wise in opposing any additional Federal regulation of the vaccine.

The L.B.C. had the necessary powers. It simply flubbed them. It must be rated as one of the main sources of the "national paralysis" that doctors are talking about. END

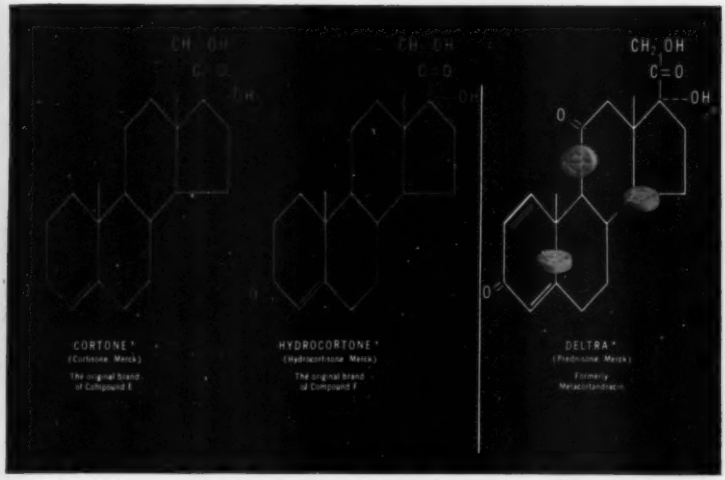


Doctor, may we have your support for

DELTRA® TABLETS

(PREDNISONE, MERCK)

(FORMERLY METACORTANDRACIN)



DELTRA is the Merck brand of the new steroid, prednisone

(FORMERLY METACORTANDRACIN)

DELTRA is a new synthetic analogue of cortisone. DELTRA produces anti-inflammatory effects similar to cortisone, but therapeutic response has been observed with considerably lower dosage. With DELTRA, favorable results have been reported in rheumatoid arthritis with an initial daily dosage of 20 to 30 mg. and a daily maintenance dose range between 5 and 20 mg.

Salt and water retention are less likely with recommended doses of DELTRA than with the higher doses of cortisone required for comparable therapeutic effect.

Indications for DELTRA: Rheumatoid arthritis, bronchial asthma, inflammatory skin conditions.

SUPPLIED: DELTRA is supplied as 5 mg. tablets (scored) in bottles of 30 and 100.

SHARP & DOHME

Philadelphia 1, Pa.
DIVISION OF MERCK & CO., INC.

FOR SUPERIOR PERFORMANCE IN ANTIBIOTIC THERAPY

—effective, safer, more sustained action with this newest broad-spectrum antibiotic

Polycycline—available in many dosage forms—affords significant clinical advantages in broad-spectrum antibiotic therapy:

Effective in broad range

—against Gram-positive and Gram-negative organisms, certain rickettsiae and large viruses.

Greater tolerance

—markedly lower incidence and severity of adverse side effects.

Greater solubility

—than chlortetracycline, yielding quicker absorption and increased diffusion in body fluids and tissues.

Greater stability

—in solution than chlortetracycline or oxytetracycline, assuring higher, more sustained blood levels.

•

Polycycline is a tetracycline produced by the unique Bristol process of direct fermentation. Its basic structural formula is free of a chlorine atom (present in chlortetracycline), and of an hydroxyl group (present in oxytetracycline).

Your pharmacist has all dosage forms of Polycycline available for your prescription:

POLYCYCLINE SUSPENSION WITH TRIPLE SULFONAMIDES

Coconut oil suspension of tetracycline with three sulfonamides. In concentration of 125 mg. tetracycline HCl with 167 mg. each of sulfadiazine, sulfamerazine and sulfamethazine per 5 cc.; in bottles of 2 fl. oz.

POLYCYCLINE AQUEOUS '250' or AQUEOUS '125'

An aqueous suspension ready to use without reconstitution. Stable for 18 months without refrigeration. Highly palatable, cherry flavor. As calcium tetracycline equivalent to 250 mg. (or 125 mg.) tetracycline HCl per 5 cc.; in bottles of 1 fl. oz.

POLYCYCLINE SUSPENSION '250'

A really palatable oil suspension, requiring no dilution or reconstitution. Needs no refrigeration—stable for 18 months. In concentration of 250 mg. tetracycline HCl per 5 cc.; in bottles of 1 fl. oz.

For accurate dosage in small amounts. In concentration of 100 mg. tetracycline HCl per cc.; in bottles of 10 cc. with dropper calibrated for administration of 25 mg. or 50 mg.

POLYCYCLINE PEDIATRIC DROPS

POLYCYCLINE AQUEOUS PEDIATRIC DROPS

As calcium tetracycline equivalent to 100 mg. tetracycline HCl per cc.; in bottles of 10 cc. with dropper calibrated at 25 mg. and 50 mg.

For deep intramuscular injection. In single-dose vials of 100 mg. tetracycline HCl per vial.

POLYCYCLINE INTRAMUSCULAR

Handy form for oral use, in two potencies of tetracycline HCl. In capsules of 100 mg.; in bottles of 25 and 100. In capsules of 250 mg.; in bottles of 16 and 100.

POLYCYCLINE CAPSULES

POLYCYCLINE OINTMENT WITH 2% XYLOCAINE*

—30 mg. tetracycline HCl with 20 mg. Lidocaine (as the base), per gram.

POLYCYCLINE OPHTHALMIC OINTMENT WITH 2% XYLOCAINE*

—10 mg. tetracycline HCl with 20 mg. Lidocaine (as the base), per gram.

*For extra margin, prod. inc. for Lidocaine.

When you think of Tetracycline, think of

Bristol
LABORATORIES INC
SYRACUSE, NEW YORK

POLYCYCLINE®

(Tetracycline HCl Bristol)

Home-Grown Malpractice Plan Costs Them Less

Faced with a stiff rise in premium rates, the M.D.s in one state refused to take it lying down. This account of how they saved money by switching carriers may give you some ideas

By John R. Lindsey

● It's a stale fact that doctors are paying more than ever before for malpractice insurance. But here's fresh evidence that they don't necessarily have to accept the spiraling rates without a fight:

Physicians in Oregon are convinced that medical men can get good results by taking concerted action against unreasonable premiums. They speak from experience.

Two years ago, Oregon was as hard hit as any state in the Union by the upswing in rates. But the doctors organized a plan of their own, worked out arrangements with an independent carrier, and cut their malpractice costs considerably. Here's *how* they did it:

For almost twenty years—up to April 1, 1953—most of the doctors bought their malpractice insurance, through the state society, from the Metropolitan Casualty Insurance Company of New York, a member of the National Bureau of Casualty Underwriters. In 1953, they were paying a base rate of $45 for $5,000/$15,000 coverage; and costs were the same for all practitioners. Contrary to the usual practice, there were no higher rates for surgeons, radiologists, partnerships, etc. [MORE ▶

Then, suddenly, this happy picture changed: Two years ago, the companies belonging to the National Bureau of Casualty Underwriters worked out a new schedule of uniform malpractice rates. They couldn't fix a national rate; but they could, and did, set a standard rate within every state. And for Oregon, at least, this caused whopping jumps in insurance costs.

From $45 to $90

The rate rise, not too startling at first, quickly gathered momentum. By last year, Metropolitan was forced to double its premiums for the physician who performed no surgery. Under the bureau's new schedule, the $45 he'd been paying for the $5,000/$15,000 limits shot up to $90. The $76.95 premium for $25,000/$75,000 coverage went to $153.90. And so on.

Surgeons (and G.P.s doing some surgery) were hit even harder. Up to 1953, as I've said, they paid the same rates as their colleagues in medicine. But by May, 1954, their $45 rate had soared to $135; their $76.95 premium, to $230.85.

For radiologists and physicians doing X-ray therapy, it was still worse: Their rates were quintupled!

What's more, under the new schedule of the bureau—and, therefore, of Metropolitan Casualty—additional charges were made for the first time: There was a big extra charge for partnership liability and for physician-employe coverage. Surgeons using X-ray therapy were confronted with premiums double the already increased rates.

Such extras are standard insurance practice in most areas. But Oregon doctors had been getting along fine without them. So they came as a rude shock.

In fact, the entire upward revision of the rate schedule seemed "arbitrary and irresponsible" to the Oregon State Medical Society's committee on malpractice. In a report to the state's doctors, the committee, headed by Dr. Karl H. Martzloff of Portland, called the new schedule "wholly fictitious" in that it disregarded "our established favorable experience" over two decades.

In the years from 1948 to 1953, the report pointed out, Metropolitan had seen no need to raise its rates. And for good reason: Of forty-eight suits disposed of during that six-year period, there had been only one jury verdict in favor of a plaintiff, as against twelve in favor of physician-defendants.

In seventeen other instances, there wasn't sufficient evidence to send the cases to the jury, or the plaintiffs failed to prosecute. Eighteen suits were settled before trial. Of the other 128 claims filed, eighty-two resulted in no payment to the claimant. Only twenty-five claims were settled, most of them for nominal sums. The average annual total paid on suits and claims during the six years under consideration: $27,000.

"That was a pretty good record," said one doctor, "when you realize that most of the state society's 1,600 members held individual policies with Metropolitan."

When Oregon's doctors decided to end their agreement with Metropolitan rather than accept the rate rise, they cast about, through the state medical society, for an independent insurance company that could grant them better terms.

What They Wanted

To begin with, though, they drew up a list of their own terms. They felt these items were essential:

1. A single carrier must be found to write malpractice insurance for the society's members.

2. The company must be willing to employ only legal counsel experienced in the defense of malpractice suits—and acceptable to the society's malpractice committee.

3. The carrier must permit the medical facts in each case to be reviewed by the society's malpractice committee in cooperation with the company's claims superintendent and legal counsel; and no claims must be settled except on the committee's recommendation. (In this way, the doctors hoped to reduce "nuisance value" payments, which contribute to rising costs.)

4. The company must agree to report annually on the actual experience—and costs—for each year and for cumulative periods of time.

5. Rates must be adjusted periodically in accordance with such actual experience.

It wasn't easy for the doctors to find what they were looking for. But they did find it—in, of all places, an automobile insurance concern. In 1953, the Oregon Automobile Insurance Company was a complete newcomer to the complex field of malpractice insurance; but it was an independent carrier, sound financially, and willing to take a chance.

During three months of negotiations, Dr. Martzloff and his colleagues on the society's malpractice committee marshaled an impressive array of facts and figures to convince the company that the chance was worth taking. Not the least of their selling points: They promised to urge the society's 1,600 members to take out individual policies with the new carrier if it could offer a "more realistic" rate schedule than the one effected by the National Bureau of Casualty Underwriters.

The doctors concluded their presentation with a clincher in the person of Hugh L. Biggs, a lawyer who has long specialized in malpractice cases. The Oregon physicians pointed out that, as legal counsel to Metropolitan Casualty, Biggs was the one man most responsible for the low loss ratio from 1934 to 1953. Biggs' services would be available to Oregon Automobile, thus assuring the carrier of a basic ingredient that it would need: namely, a medicolegal expert who knew all the angles.

Once convinced, Oregon Automo-

bile submitted a rate schedule acceptable to the committee. Premiums were to be $55 for $5,000/$15,000 limits, $90 for $20,000/$60,000, $104 for $50,000/$150,000, and $113 for $100,000/$300,000. These premiums, though fairly steep in comparison with Metropolitan's old rates, seemed good in relation to Metropolitan's new rates.

Unfortunately, they were too good to be true: The carrier had worked out its schedule on the assumption that it could get reinsurance on the higher limits of liability through the usual channels and at the usual rates (a practice followed by most casualty insurance carriers). This proved a false assumption.

As Dr. Martzloff and his colleagues say in their committee report, "It was almost unbelievable—but it was true—that all responsible American reinsurance companies refused to write any reinsurance of this type for any company outside the National Bureau of Casualty Underwriters. The only reinsurance finally obtainable was through Lloyd's of London."

As a result, the proposed rates had to be jacked up a bit. The $90 estimate for $20,000/$60,000 coverage went to $107; the estimated $104 for $50,000/$150,000 went up to $124; and the premium for $100,000/$300,000 became $135 instead of $113. Only the $55 base rate for the $5,000/$15,000 limits (which Oregon Automobile felt no need to reinsure) remained the same.

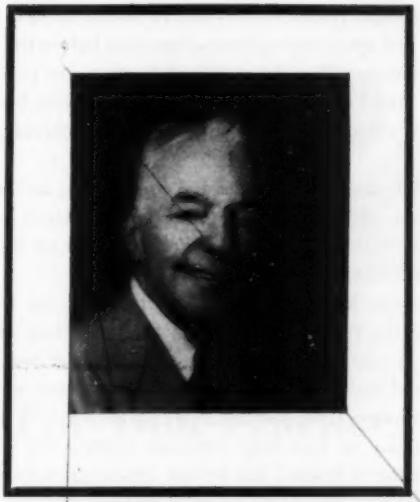
Yet recently, after less than two years' trial, the carrier was able (with Lloyd's backing) to cut its rates 5 per cent in every category above the basic $5,000/$15,000 limits. And under the new plan, as in 1934-53, costs continue to be uniform for *all* practitioners, regardless of specialty. The only extra charge is for partnerships (25 per cent of the individual rate added to each partner's premium).

Future Looks Good

So far, more than 1,000 Oregon doctors have bought policies with the Oregon Automobile Insurance Company. "As long as we continue to have the support of most members of our medical society," says the society's executive secretary, Clyde C. Foley, "the outlook for our program is promising. Up to now, certainly, the society has no reason to regret its refusal to bow to the mandate of the National Bureau of Casualty Underwriters."

Do the Oregon men think their experience can help doctors in other states? Well, the malpractice problem differs so widely from state to state that it's hard to generalize on methods of handling it.

"But we're sure of one thing," says Executive Secretary Foley, "We know now that in areas where malpractice rates seem unjustifiably high, doctors don't have to take supinely whatever insurance companies offer them. They can still fight back." END



H. Sheridan Baketel, M.D.

• On July 7, at his home in St. David's, Pa., death came to Dr. H. Sheridan Baketel, editor-in-chief of MEDICAL ECONOMICS. He had been associated with this magazine ever since he helped found it in 1923.

He was more than a medical editor. During his eighty-two years, he'd been a country doctor, a big-city specialist, an Army colonel, a medical educator, a leader in pharmacy and in the drug industry. The pages of MEDICAL ECONOMICS reflected the broad sweep of his interests.

Dr. Baketel was born in Hopedale, Ohio, the son of the Rev. and Mrs. Oliver S. Baketel. He attended Phillips Exeter Academy, Boston University, and Dartmouth College, receiving his M.D. from the last in 1895. Later he did post-graduate work at Harvard and abroad. [MORE▶

He began practice as a country doctor in New Hampshire and spent several years there just before the turn of the century. Then he switched to specialty practice in New York City, becoming affiliated with New York Hospital, Beekman Hospital, and others, as attending urologist.

While in New York, Dr. Baketel became interested in medical editing. He was editor of Gaillard's Medical Journal from 1905 to 1908. For fifteen years thereafter he was editor of the Medical Times.

He also became interested in teaching. In 1915, he joined the faculty of the Long Island College of Medicine. It was there that he pioneered in the teaching of medical economics, conducting the first such classes in the country. This led to his collaboration with Lansing Chapman in founding MEDICAL ECONOMICS, the first magazine of its kind. His by-line appeared on its editorial page each month for the next thirty-two years.

He still kept up all his outside interests. From 1929 to 1931, he was president of the American Pharmaceutical Manufacturers Association. From 1938 to 1942, he was board chairman of Columbia University's College of Pharmacy. He was a longtime fellow of the American College of Physicians and other medical societies too numerous to mention.

Throughout his diverse career, he never failed to put his profession first. His views on this subject were well expressed in an editorial he wrote for MEDICAL ECONOMICS in December, 1923. It was entitled "The True Physician," and it concluded:

"Some men are referred to as 'born physicians.' Medicine is both their vocation and their avocation . . . They are constantly doing their bit toward keeping the profession what we believe it to be—the noblest of all callings . . . Such is the True Physician."

Such was H. Sheridan Baketel, M.D.

Yardsticks For Your Practice

Two physicians in neighboring towns were thinking of going into partnership together. Then they had their practices analyzed by the same management consultant. What they learned proved so illuminating that they decided to stay solo and revamp their existing practices as recommended by the consultant. Here are verbatim excerpts from his reports. They offer a host of practical, interesting ideas that can be applied in your own office. Horace Cotton, the author, is director of Professional Management, Charlotte, N.C. Except for necessary disguising of identifying details, his findings appear on the following pages exactly as submitted to the doctors

PROFESSIONAL MANAGEMENT

WORK SHEET

DR. James A. Xavier STUDY BY Horace Cotton DATE

(ADDRESS) 65 Broad Street

(CITY AND STATE) Nonesuch, N.C.

THE PRACTICE

SOLO	2 MAN	3 MAN	PLUS 3	G. P.	INT.	PED.	OB&GYN	GEN. SURG.	OTHER (SPECIFY)
Yes	–	–	–	Yes	–	–	–	–	Pediatrics, OB

EXTEND DATA ON PRACTICE (ATTACH COPY OF ANY PARTNERSHIP AGREEMENT)

See other side.

PREMISES

TOWN	SUBURB.	RURAL	PROF. BG.	AD HOC	COMMER.	NEW	OLD	ATTRACT.	MI. HOSP.	PARKG.	STAIRS	AIR COND.	LIG.
Yes	–	–	–	Yes	–	Yes	–	Nery	½	Lot	No	Yes	

EXTEND DATA ON PREMISES

See other side.

SPACE AND FACILITIES

RECEP.	CONSULT.	EX. #1	EX. #2	EX. #3	LAB	X-RAY	BUS	LAYOUT	DECOR	FURN.	MUSIC	RADIO	TV
O.K.–	O.K.+	O.K.	O.K.	O.K.	O.K.	O.K.	O.K.–	O.K.	O.K.–	O.K.–	No	No	

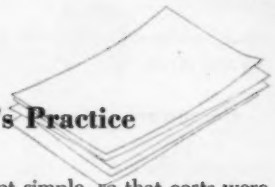
EXTEND DATA ON SPACE AND FACILITIES

See other side.

PERSONNEL – MEDICAL

NAME IN FULL	A. L. S.	M/S/W	CHILDR.	MED. QUAL. FROM	CLASS	BOARDS
1. James Alwyn XAVIER	41	M	3	Un. of Va.	'39	None
2.						
3.						

STUDY OF A PRACTICE begins with this work sheet, reproduced here only in part. The complete form has five pages and lists nearly 500 checkpoints on which a practice can be rated. Excerpts from the finished report to Dr. James Xavier comprise the text that starts on the opposite page.



Report on Dr. Xavier's Practice

The Practice: This is a busy general practice that runs heavily to pediatrics and OB care. It was established Jan. 1, 1953, after Dr. Xavier terminated his association with an older colleague. It serves a town of 26,000. Many patients are textile workers, subject to cyclical unemployment.

The practice has grown rapidly; Dr. Xavier has taken no time off since starting it. Between forty and fifty patients are seen in a day. House calls are few. The office is so well equipped that patients realize it's in their interest to go there if possible.

Last year the practice grossed $33,035, netted $21,740. Considering the number of patients and the investment in facilities, these figures don't seem commensurate. Though the practice is booming, perhaps it has grown too fast for its own good.

The Premises: Without question, Dr. Xavier has the best professional office in town. It was built to his order in late 1952. It's located on an attractive corner a half-mile from the hospital. There's off-the-street parking for eighteen cars.

Through striking skylights, the building makes notable use of natural lighting. It's also air-conditioned throughout. Construction was kept simple, so that costs were relatively low. For his outlay, the doctor has a fine property.

Space and Facilities: Clinical areas are exceptionally well laid out. The doctor can circulate around five or six rooms without taking more than ten steps in any direction. Though his practice is large, there's treatment space to spare.

Reception and business areas are less satisfactory. For one thing, the reception room is so simply furnished as to seem cold and austere. For another thing, it's around a blind corner from the business office. As a result, the secretary has developed the bad habit of calling out patients' names to summon them. This should be stopped; she should come around the corner and escort them.

Better yet would be to eliminate the blind corner. This could be done quite easily by removing the corner closet, enlarging the business office in that direction, and installing a glass panel on the reception-room side.

The business office itself needs to be rearranged. The hall counter is too high; the secretary's desk is too far from it. The secretary should be able to sit so that she commands counter, desk, and files from her

chair, without continually bobbing up and down.

Personnel—Medical: Dr. Xavier is a dynamic person of brisk and energetic manner. He is more interested in providing good medical care to the greatest number of patients than he is in the business details. In fact, he seems somewhat impatient of the business side. This has perhaps made his practice more of a strain on him than necessary.

His previous association with an older doctor in town lasted nine years. It was rewarding professionally, but I gather he much prefers solo practice. The only reason he's considering bringing in a partner now, Dr. Xavier says, is that his practice threatens to grow too large for one man to handle.

MINOR CLINICAL FUNCTIONS can be delegated routinely to his nurse, Dr. Xavier is assured in this report.

Personnel—Other: The doctor employs a nurse, a secretary, and a part-time janitor. All have been with him since this practice began. In my opinion, their usefulness to him has not been fully developed.

The nurse, Miss Cabell, is an exceptionally capable woman. She does a fine job of preparing patients for treatment. She also changes dressings, gives injections, and performs other minor clinical functions when Dr. Xavier specifically delegates these tasks. From all accounts, she handles them well.

It seems to me the doctor could delegate such tasks almost routinely. He could thus capitalize on Miss Cabell's talents and make her more valuable to him. Even now, her salary ($225 a month) is on the light side; and it hasn't been raised for more than a year. The soundest personnel policies are built around *small raises every six months,* up to the limit you can pay.

Mrs. Hollister, the secretary, is paid $200 a month plus a quarterly bonus that's actually a commission on collections—i.e., 2 per cent of the excess over $5,000 collected per quarter. This adds about $20 a month to her pay. I'd be inclined to dispense with the commission. I don't like to see a professional in-

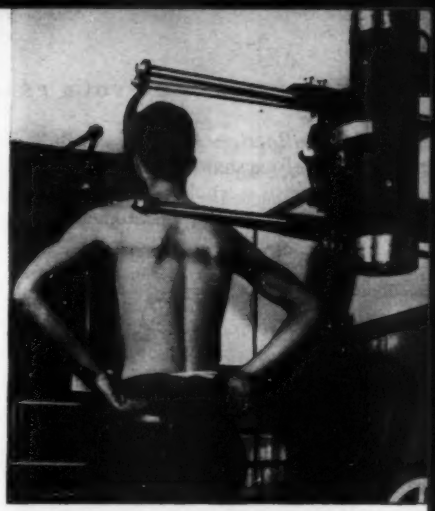
come shared with a nonprofessional person, even to this small extent.

Ordinarily, the secretary's salary could be increased enough to make up the difference. But in all frankness, a question must be raised as to how much Mrs. Hollister is worth. While a small practice can get along with a secretary who lacks typing and bookkeeping skills, a large practice almost never can. It seems to me that the business side of Dr. Xavier's practice may have outgrown Mrs. Hollister's capabilities. (This is not to discount her possible usefulness as a receptionist.)

Equipment: As noted previously, the complete array of professional equipment influences patients to come into the office. It's equipped with X-ray, fluoroscope, diathermy, BMR, ECG—some $8,000 worth of professional equipment in all.

Business-office equipment is not up to this high standard. The adding machine is a manual type, rather awkward to operate. The typewriter is extremely old, with a keyboard not well suited to a medical office. There's no dictating machine, no intercom, no check writer. Several hundred dollars invested in new business equipment would increase efficiency a great deal.

Business Methods: An oversimplified day book is used. It has two columns: one for charges, one for cash. There are no monthly summaries. I understand that a tax examiner recently suggested to Dr. Xavier that a more complete bookkeeping system would be desirable. In my opinion, this is a must.



MAJOR DIAGNOSTIC EQUIPMENT enables Dr. Xavier to save some patients a visit to the local hospital.

Other bad business practices have developed. The doctor himself handles bank deposits, visiting the bank only once or twice a week. Deposit slips are not itemized or retained. And not all cash receipts are banked, some being used to pay small office expenses like postage.

Daily deposit of *all* receipts is essential in a practice of this size. So is the paying of all bills by check. So is the maintenance of separate checking accounts for professional and personal use. (At present, both types of expenses are paid out of the same account.) [MORE ▶

Collection Procedure: Billing is fairly systematic; collection procedure as a whole is not. I say this because monthly statements are about the only device used. If an account isn't paid within a few months, it's often carried on the books without further follow-up.

BUSINESS-REPLY MAILERS are recommended for Dr. Xavier's statements. They're said to bring maximum returns.

Dr. Xavier believes his collections run 90 per cent or better, but he has no figure to support this. He further believes that periodic unemployment among local textile workers calls for "easy" collections. I recognize the problem, but the present arrangement doesn't solve it. Instead, it gives slow payers a free ride, whether or not they rate it.

Any collection system can be modified to meet individual situations. But the first requisite is to have a *system*. Here's what I suggest:

A. Use charge slips in the office, so the patient will know the charge before he leaves. If it's $5 or less, encourage payment on the spot.

B. Use business-reply mailers (statements typed on fold-over return envelopes) for all new accounts not paid in cash. Begin making them up on the twenty-fifth of the month. Mail them in window envelopes on the thirtieth without fail.

C. Send a second mailer the following month if no payment has been received or if no payment arrangement has been made.

D. Send a special letter the third month. The secretary should sign it in ink with her own name.

E. Send different letters the fourth, fifth, and sixth months, if necessary, and supplement them with telephone calls.

F. After six months, assemble the facts about any account remaining unpaid. On the basis of these facts, decide whether to write it off or to place it with a collection agency.

G. At least twice a year, conduct an age analysis of all outstanding accounts. See whether time-payment arrangements can be made with people owing large amounts.

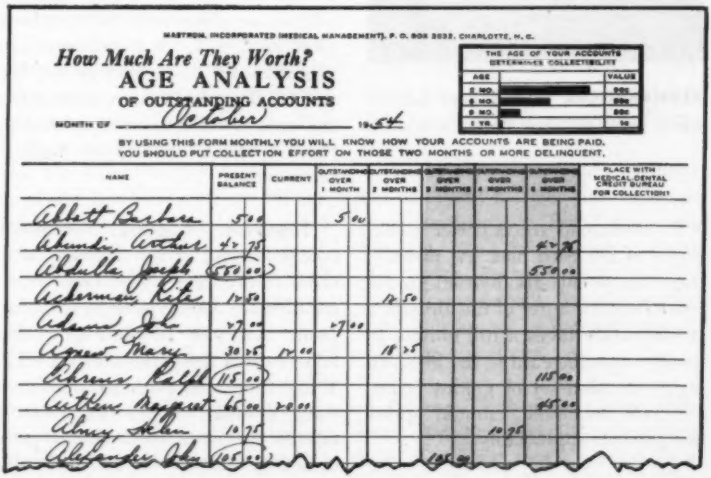
Dr. Xavier's books don't permit a complete analysis of his accounts. But a spot check indicates that his collections are running nearly $1,-

000 a month behind billings. This loss of income appears unrelated to textile layoffs: There haven't been any for months.

Patients' Records: Case histories are handwritten on 5" x 8" cards. The doctor's notations are quite abbreviated. This is common in a practice of this type. A busy G.P. can't keep the elaborate records that an internist can.

Even so, it's my impression that obstetrical and surgical records should be fuller—this for the doctor's own protection in case of malpractice claims. If he used a dictating machine (and if he had a secretary capable of transcribing clinical comment), he'd have superior records to show for the same expenditure of time.

I note that financial data about Dr. Xavier's patients are recorded on their case-history cards. This is highly inadvisable. Medical records are privileged; financial records are not. And both types are sometimes needed simultaneously in different parts of the office. [MORE ▶



MASTRON, INCORPORATED MEDICAL MANAGEMENT, P. O. BOX 2032, CHARLOTTE, N. C.

How Much Are They Worth?

AGE ANALYSIS

OF OUTSTANDING ACCOUNTS

MONTH OF October 1954

THE AGE OF YOUR ACCOUNTS DETERMINES COLLECTIBILITY

AGE	VALUE
0 MO.	90%
6 MO.	50%
9 MO.	20%
1 YR.	10

BY USING THIS FORM MONTHLY YOU WILL KNOW HOW YOUR ACCOUNTS ARE BEING PAID. YOU SHOULD PUT COLLECTION EFFORT ON THOSE TWO MONTHS OR MORE DELINQUENT.

NAME	PRESENT BALANCE	CURRENT	OUTSTANDING OVER 1 MONTH	OUTSTANDING OVER 2 MONTHS	OUTSTANDING OVER 3 MONTHS	OUTSTANDING OVER 4 MONTHS	OUTSTANDING OVER 6 MONTHS	PLACE WITH MEDICAL-DENTAL CREDIT BUREAU FOR COLLECTION?
Abbott, Barbara	5 00		5 00					
Abundis, Arthur	47 75						47 75	
Abdulla, Joseph	(550 00)						550 00	
Ackerman, Rita	12 50			12 50				
Adams, John	27 00		27 00					
Agnew, Mary	30 25	12 00		18 25				
Ahrens, Ralph	(115 00)						115 00	
Aitken, Margaret	65 00	20 00					45 00	
Almy, Helen	10 75					10 75		
Alexander, Abe	(105 00)				105 00			

UNPAID ACCOUNTS should be "age-analyzed" every six months, Dr. Xavier is told. Using a form like the one shown here, he can quickly identify his oldest and largest outstanding accounts. He can then direct special follow-ups.

I strongly recommend that a separate set of financial cards be installed. Also, that they be kept in much greater detail than at present—even including the gist of pertinent telephone conversations.

ALPHABETICAL FILING goes quicker when more division guides are used.

I recommend, too, a better breakdown of the card files. At present, there are twenty-six division guides—one for each letter of the alphabet. It frequently takes a full minute to locate a specific card in the files. An eighty-division set of guides (commercially available) should speed this process appreciably.

Fees: Sometimes the patient asks what the fee is; the doctor tells him; and the patient pays cash. More often, there's no discussion of fees. The doctor writes the charges in the day book after the patient has left.

This is unfair to all concerned. If Dr. Xavier dislikes discussing fees, he should bring up the subject in some other way—e.g., through the use of charge slips. No one should leave the office without knowing the cost. No one should undergo a major procedure without knowing the cost *ahead of time*.

Dr. Xavier's fees have not changed since he started solo practice. This was a temporarily depressed area then; it is not now. Per capita income is higher today than in most other counties of this state.

By any standard, the fees that Dr. Xavier most commonly charges—$2 for an office visit, $4 for a hospital visit, $75 for a delivery—are unrealistically low. Fees of $3, $5, and $100 would be more normal for this area. If collected systematically, they'd provide the doctor with a fairer return.

Insurance Claims: Workmen's compensation, Blue Shield, and other insured cases that Dr. Xavier handles are usually seen in the hospital. And the hospital generally takes care of the paperwork for him. While there's no evidence that anything is amiss, it's in the doctor's interest to have such claims processed by his own office. This should be his ultimate goal.

At the moment, the few compensation claims being handled by his office are much in arrears. The rea-

sons have been mentioned previously: (1) too sketchy medical records, forcing the secretary to consult with the doctor about each claim, and (2) too little typing talent. I'm told the doctor himself fills out some forms in longhand. Obviously, he shouldn't have to.

Appointments: Dr. Xavier uses a "modified appointment system." People who phone in and ask for a specific time are given it. They're seen as soon as they arrive, even if this means taking them ahead of others who have been waiting.

This system has never been formally announced, so most patients just drop in. Their waits range from several minutes to hours.

From my observation, the present system pleases a few people and irritates many. Among those irritated are the doctor and his aides, who find it almost impossible to organize their day. Dr. Xavier would like to schedule ahead, but he fears that a full appointment system would scare off some patients. On the other hand, he wonders whether patients aren't being lost by the present uncertainty about when they'll be seen.

I feel strongly that the doctor should move toward a middle ground. He can offer appointments for obstetric cases, pediatric cases, and all revisits. He can post a notice in his reception room; he can enclose an announcement with his bills. Regular patients will quickly acquire the habit of phoning for appointments. Time can still be left free for newcomers who drop in.

Reception of Patients: It's possible that I hit two bad days. The first day, I was in the reception room twenty minutes before being noticed. The second day, I got a hasty hello—and that's all. It's not fair to pass final judgment on this basis. But I noticed the secretary seemed equally unconcerned about others waiting.

Of course, she's handicapped by the physical separation of the reception room and the business office. As soon as this is corrected, certain ground rules will be in order. I'd recommend these:

Greet every visitor within one minute of his arrival . . . Use his *name* as soon as you know it . . . And *usher* him to the doctor when his time comes; don't just give directions.

Mrs. Hollister has not yet acquired the confident manner that marks a good receptionist. But I think it's because she's preoccupied with other work. Perhaps she's also a little unsure of herself. It would probably bolster her self-confidence if she wore a uniform.

Phone Technique: Mrs. Hollister has the friendly, reassuring way of talking that's needed in a doctor's office. She speaks slowly, with good diction, and accentuates the positive. (NOT "The doctor is out," but "The doctor will be in at

PROFESSIONAL MANAGEMENT

WORK SHEET

DR. Henry J. Yancey — STUDY BY Horace Cotton — DATE

ADDRESS: 135 County Road
(CITY AND STATE): East Nonesuch, N.C.

THE PRACTICE

SOLO	2 MAN	3 MAN	PLUS 3	G. P.	INT	PED.	OB&GYN	GEN. SURG.	OTHER (SPECIFY)
Yes	–	–	–	–	–	Yes	–	–	–

EXTEND DATA ON PRACTICE (ATTACH COPY OF ANY PARTNERSHIP AGREEMENT)

See other side.

PREMISES

TOWN	SUBURB	RURAL	PROF. BG.	AD HOC	COMMER.	NEW	OLD	ATTRACT.	MI. HOSP	PARKG.	STAIRS	AIR-COND.	LIFT
–	Yes	–	–	–	Yes	–	Very	No	5	St.	Yes	Yes	

EXTEND DATA ON PREMISES

See other side.

SPACE AND FACILITIES

RECEP.	CONSULT.	EX. #1	EX. #2	EX. #3	LAB	X-RAY	BUS.	LAYOUT	DECOR.	FURN.	MUSIC	RADIO	TV
N.G.	N.G.	O.K.–	O.K.–	–	–	–	N.G.	O.K.–	N.G.	N.G.	No	No	

EXTEND DATA ON SPACE AND FACILITIES

See other side.

PERSONNEL – MEDICAL

NAME IN FULL	A. L. B.	M/S/W	CHILDR.	MED. QUAL. FROM	CLASS	BOARDS
1. Henry Jason YANCEY	37	M	2	Bowman Gray	'43	Am. Bd. Ped.
2.						
3.						

SECOND STUDY deals with the practice of Dr. Henry Yancey, with whom Dr. Xavier had been considering a partnership. Both doctors eventually decided against teaming up. They figured they'd do better in solo practice. From these reports, you can see why.

10:30. May I help you?") She'd do well at telephone collections, I think.

Major Recommendations: Recognizing Dr. Xavier as a man of action, I see no need to recapitulate the changes suggested above. In sum, they add up to more efficient management. I am confident that he will want to work them out as indicated.

There remains the proposed partnership with another doctor. This is a question that Dr. Xavier must eventually decide for himself. But I can shed some light on a related question: Is his practice getting too big for one man to handle? My answer must be recorded as "No."

The immediate need in Dr. Xavier's case is not another doctor but another aide. An experienced secretary-bookkeeper will break the bottlenecks in his office. Mrs. Hollister, meanwhile, can be used to good advantage as a receptionist and a telephone collector, perhaps on an hourly basis.

Competent aides cost money—but they bring in money, too. In fact, I'll predict flatly that by spending more on salaries, Dr. Xavier can increase his own net earnings.

In the same way, he can greatly increase the satisfaction he gets from practice. For satisfaction stems from such things as a smooth-running schedule, the painless handling of paperwork, the ability to do a lot for patients in relatively little time.

In an office that's understaffed, *two* doctors won't find these things. Surrounded by sufficient aides, *one* doctor will.

Report on Dr. Yancey's Practice

The Practice: This pediatric practice was started in June, 1950. It serves a town of 13,000, a drawing area of about 25,000. There are many well-to-do farm families among its clientele. Their referrals provide most of Dr. Yancey's new patients; he gets very few physician-referrals.

Progress has been steady but not spectacular. Between twelve and twenty patients are seen in a day, quite a few of them on long-distance house calls. The practice last year grossed $19,775 and netted $11,130.

Net earnings seem low in relation to volume. But in my opinion, the volume itself is too low. A successful pediatric practice needs good volume.

The Premises: Dr. Yancey's office is up one flight in an old com-

mercial building with no elevator. The stairs must be a deterrent to some mothers. The building's exterior is unprepossessing; the interior is poorly lighted. The only toilet facilities are public, down the hall.

Dr. Yancey picked this location five years ago because of the low rent: $70 a month. He stayed on because he got used to the place. He's been able to overcome some of the building's handicaps—by installing three window air conditioners, for example. But, pretty clearly, his present surroundings retard the development of his practice.

It speaks well for Dr. Yancey's reputation that well-to-do farm families come to him anyhow. They would undoubtedly come in greater numbers if he moved to a better building.

OPEN-SHELF FILES fit easily into a hallway. They're well suited to an office like Dr. Yancey's, where there's insufficient space for cabinet files.

Space and Facilities: Layout is surprisingly good, but most of the rooms are too small. Dr. Yancey has about 625 square feet of floor space; he could use 800 square feet.

The reception area seems especially cramped. To have the secretary's desk right in the reception room is occasionally all right in spacious quarters; it's bothersome here. Waiting patients sit practically in the secretary's lap.

I don't recommend rearrangement of the present floor plan. No matter how you slice it, the space is inadequate. But if Dr. Yancey doesn't move to larger quarters right away, I *do* recommend some renovation to dispel the gloom. It undermines visitors' confidence in the doctor.

For the best job of brightening up that can be achieved at modest cost, I suggest that he (1) remove all dark draperies; (2) repaint the reception and consultation rooms in pastels; (3) get a new lighting plan; and (4) install a false ceiling in the consultation room (with its 20-foot ceiling and dark decor, it must remind many visitors of a tomb).

Personnel—Medical: Dr. Yancey likes to take things slowly. He is extremely conscientious about his work. He spends one to two

hours with a new patient, as much as half an hour with an old one. He makes a point of letting mothers "have their say."

It is no part of my function to suggest how a physician should practice medicine. But there are facts relative to the practice of medicine that I feel bound to bring to his attention. One is the fact of *time:*

The combination of time and skill is all the physician has to offer. The right combination of these makes him of greatest usefulness to society —and therefore produces the right kind of professional income.

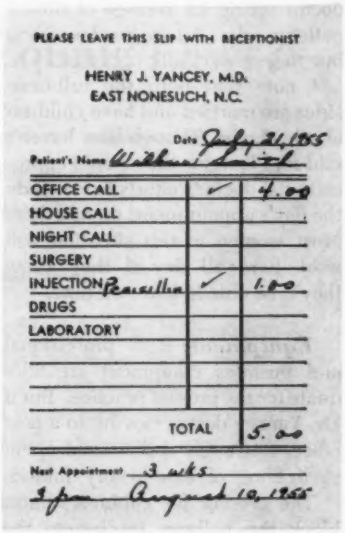
As of now, Dr. Yancey does not have the right combination. He gives away too much time. He therefore limits both his usefulness and his rewards.

When a skilled physician organizes his time so that he becomes available to more patients, the additional patients are not long in finding him. I suggest that Dr. Yancey try scheduling new patients for forty-five minutes and old ones for fifteen minutes—the actual time spent to be adjusted to clinical needs. I further suggest:

A. That the secretary use an inconspicuous light signal to remind the doctor when the time for the next patient is due; and

B. That mothers be educated into dressing and undressing their own children.

Personnel—Other: Dr. Yancey employs a nurse, a secretary, and



PLEASE LEAVE THIS SLIP WITH RECEPTIONIST

HENRY J. YANCEY, M.D.
EAST NONESUCH, N.C.

Date July 21, 1955

Patient's Name William Smith

OFFICE CALL	✓	4.00
HOUSE CALL		
NIGHT CALL		
SURGERY		
INJECTION Penicillin	✓	1.00
DRUGS		
LABORATORY		
TOTAL		5.00

Next Appointment 3 wks
3 pm August 10, 1955

CHARGE SLIPS make the rounds with each patient in Dr. Yancey's office. They're eventually brought back to the secretary's desk, where many visitors pay the indicated charges in cash.

a part-time bookkeeper. The first two are paid $225 a month. The bookkeeper, on an hourly basis, gets about $100 a month. The total payroll runs to $6,500 annually—too high for a medical practice of this size.

If the doctor takes steps to expand his practice, he can probably support his present payroll. Otherwise, I must recommend that the secretarial and bookkeeping jobs be combined. Three aides are a lot for one

doctor seeing an average of fifteen patients a day. All are good workers, but they aren't fully occupied.

I note that both the full-time aides are married and have children of school age. Though they haven't said so, I imagine they would appreciate the doctor's efforts to conclude the day's appointments on schedule. Most women in this situation will work hard all day if they know they'll be able to leave on time.

Equipment: Both professional and business equipment are adequate for the present practice. But if Dr. Yancey delays moving to a new office, I strongly recommend open-shelf filing of case-history folders.

The present file cabinets almost block the hallway leading to the treatment rooms. Open-shelf files would require less than one-third as much floor space.

Business Methods: Adequate except for one thing: The doctor himself attempts the reconciliation of bank statements. He says he never can get his own figures to agree with those of the bank, so he eventually gives up and assumes the bank's statement is O.K. This task might well be delegated to one of his aides —the one who doesn't write checks.

Collection Procedure: Cycle billing is used. On the first day of the month, statements are sent to all persons whose names begin with A; on the second day, to all the Bs; and so on, throughout the month. This system has the advantage of spreading the work load in the office. But it has some disadvantages, too.

Nearly all creditors in this area—stores, utilities, other doctors—use end-of-the-month billing. So bills arriving at other times are apt to be put aside.

Cycle billing also makes it difficult for the doctor to tell the status of his accounts. Dr. Yancey's books bear this out: His over-all collection ratio is a respectable 85 per cent. But because he routinely uses charge slips, about half his collections are in cash at the time of service; and these cash collections are 100 per cent collections. Which makes his collection ratio on *billed* business a not-so-respectable 70 per cent.

End-of-the-month billing is preferable to cycle billing, in my opinion. At the end of each monthly period, the doctor knows exactly how many slow payers he's got (two statements without a response) and exactly how many delinquents (four follow-up letters without a response). He can tell his aides what action to take, then forget about it for another month.

This isn't possible with cycle billing. The physician has to be bothered every day. I believe Dr. Yancey should switch over.

Patients' Records: Preprinted case-history sheets are used. The secretary begins them, the nurse and the doctor continue [MORE ON 229]

Stymied by Zoning Laws?

Here's what to do when local ordinances block your way. Here, in other words, is how to put your office where you want it

By Thomas Owens

● A Midwestern G.P. decided last year that his booming practice had outgrown his cramped home-office. He had dreams of a trim, stone-faced office building spacious enough for himself and for a future junior partner; so he invested in a big lot in a rapidly developing section of town.

But the office never got built. And just a few months ago the doctor sold the property. The reason: He'd been stymied by zoning restrictions.

Only after buying the land had he learned that home owners in the neighborhood were stubbornly opposed to *any* kind of office building. And it was impossible to get a modification of the "residential" classification over their heated protests.

Nor is the case cited an isolated one. In these days of mushrooming cities and suburbs, more than one physician has run head-on into zoning ordinances when trying to put up an office building. An occasional M.D. has even had trouble opening an office in his own residence. Says one such physician: "Today's homeowner seems more eager to protect the value of his property than the health of his family."

What can you do when zoning restrictions stand in your path? Sometimes, of course, there's nothing you can

do. But often the problem can be solved if approached in the right way.

Two Philadelphia doctors, for example, decided to put up a modest, two-man office building in a residential area of that city. But, in anticipation of zoning trouble, they tackled the project with real intelligence.

Here's a step-by-step account of what they did:

Money-Back Clause

First, they hedged their investment in the lot they bought by insisting on a "condition precedent" clause in the sales agreement. This clause stated that if the doctors weren't able to get permission to build their office, the sale would be automatically canceled.

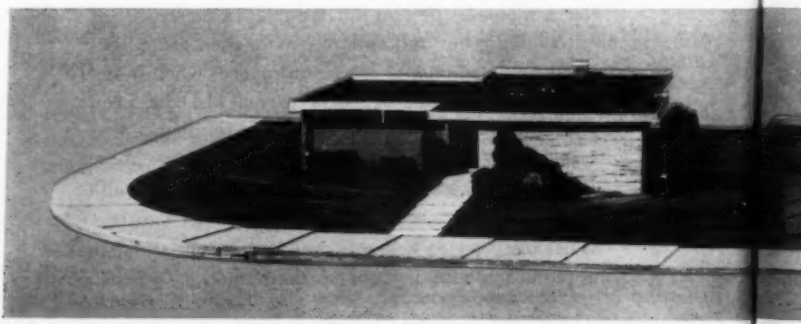
Next, their architect made a simple sketch of the building and went through the formality of applying for a building permit. As the doctors had feared, the permit was denied, because the area was zoned for residences only.

The architect then drew detailed plans of the proposed office and made a scale model of it. The 30" x 30" model—designed on a scale of one-quarter inch to the foot—was built of balsa wood and plexiglass. It was, in every respect, a treat to the eye.

M.D.s Become Salesmen

Finally, the two doctors started off on what they now refer to as their "Fuller Brush" campaign. They personally carried the model on a door-to-door tour of 300 homes in the area around their building site.* At each house they asked: "Would you object to a zoning change allowing this doctors' office to be erected?"

*Such a remarkable tour de force staggered us, too. So we questioned the two doctors in detail. They told us: "We not only trudged around with that blasted model, but we did it during the coldest week of the winter. We spent two evenings and two full days—Saturday and Sunday—lugging it around. And on the fifth day, we rested." —Ed.



The neighbors' reaction? Everyone apparently liked the idea of a medical building within walking distance. Everyone seemed flattered at being consulted beforehand. Some even offered suggestions for "improvements" in the design of the office.

After such a successful grass-roots canvass, the doctors figured that the business of getting a zoning change would be a mere formality. And they were right: When the Board of Zoning Appeals held a public hearing on the doctors' plea, not a single neighbor entered an objection. So the board voted unanimously to let the physicians go ahead with their project.

They Tackled the City

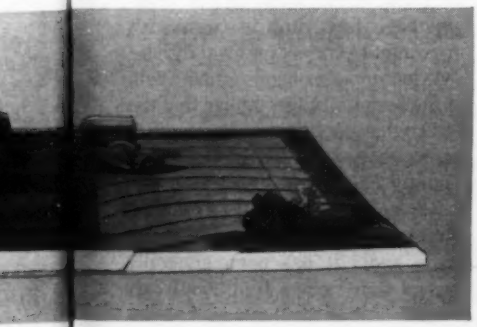
Anyone who has ever passed a psychology exam will agree that the Philadelphians hit on an effective program for nipping potential opposition in the bud. But each man must, of course, tailor his solution to fit his particular zoning problem. *Your* stumbling block, for instance, may be reluctant town officials rather than neighboring property owners. What to do then?

Here's a case history of how two medical men handled just such a situation:

They wanted to move to a Chicago suburb, put up a building there, and practice as partners. But they discovered that the town wouldn't permit office buildings anywhere but in a tiny downtown area and that office space in existing buildings just wasn't available. (One busy local G.P. had to be satisfied with a waiting room eight feet square.)

They also learned that it wouldn't even be possible for them to open separate offices in their own residences. Town officials claimed that this, too, would violate the zoning law.

So the physicians engaged a lawyer, who arranged a meeting for



THIS SCALE MODEL of a proposed medical office proved the key to a successful campaign for a zoning change. Two Philadelphia doctors carried the model on a tour of 300 homes in the area surrounding the office site. Flattered by such thoughtfulness on the part of the doctors, homeowners offered no protest.

them with the president of the town council and the town counselor. As a result of this get-together, the latter agreed to recommend that the town council permit professional office buildings in certain areas outside the central business sector. They made their decision on the basis of the following arguments (marshaled by the doctors):

¶ The zoning laws were actually depriving local residents of adequate medical service: Only eight physicians were currently serving a population of about 14,000.

¶ No doctor could *legally* be prevented from opening an office in his residence. (The physicians' lawyer was able to convince the two officials of the validity of this point.)

¶ Unless doctors were permitted to erect office buildings in residential areas, home-offices would eventually sprout up all over town—even in the most exclusive sections.

The Compromise Works

The town council later voted as the doctors hoped it would; but it *did* set up some restrictions on professional buildings. It ruled, for instance, that they could be erected only in areas already zoned for multiple dwellings. And it specified that off-the-street parking for patients must be provided.

But the doctors felt that such rules were perfectly reasonable. They're now building an office on a 265′ x 100′ lot that allows both for parking and for future expansion. And a third new practitioner is planning to put up a small office on the other side of town.

Normally, you won't encounter zoning problems until you try to build in a strictly residential area. But, as the above men discovered, an M.D. sometimes stirs up opposition even when he wants simply to open an office in his home. And in such cases, the opposition may not always be open and identifiable.

The doctor may find, for example, that his request for a building permit to add an office wing to his residence meets an endless series of delays. Or, if he's going to build a new house—and if the blueprints indicate a portion reserved for an office—the town building commissioner may withhold approval unless expensive changes are made.

Says one G.P. who successfully weathered this type of passive resistance: "Patience is usually the solution. A doctor—especially one who's new in town—may not help his practice if he tries prodding officials into action when they're dragging their feet. But, of course, it's important to know your legal rights."

What *are* your legal rights? Well, most communities recognize that the M.D. who practices in a home-office isn't engaged in business, but in "gainful employment accessory and incidental to residence." From the time zoning first started (about forty years ago), it has been generally agreed that such a traditional "accessory" use of the home isn't meant

to be excluded when an area is designated as residential.

Thus, most zoning laws specifically allow the professional man to open a home-office in a residential district. But, in order to prevent abuses, certain limitations are often included—for example:

¶ Not more than two persons may be employed to work in the office.

¶ At least 50 per cent of the total floor space must be used for residential purposes.

¶ The doctor must provide ample parking space for patients—or must at least make sure that street parking doesn't become a nuisance.

¶ If the doctor moves elsewhere, he may not continue to have an office in his former home. END

In the Bag

● Several years ago, I was interning on emergency service when I got an ambulance call for a patient with "female trouble." It turned out to be a maternity case.

The young woman—unwed, from the look of her ring finger and the horror of her assembled relatives—had her baby soon after my arrival. She took the delivery in her stride; but her mother kept groaning in agony: "Oh, Doctor, what *will* the neighbors think?"

From the window I could see every busybody in the tenement district gathered around the ambulance. I figured I couldn't leave the bawling new arrival in the flat to announce his unlawful arrival to the neighborhood. But how could I spirit both mother and child away without making the situation equally apparent?

Suddenly, I thought of a way to do it: The driver and I took the mother out in the stretcher; but when we placed her on it, I also dumped the contents of my medical bag under the blanket. Then I returned to the flat, wrapped the baby in a towel, tucked him in the bag, and rushed back down to the ambulance.

As I hurried through the crowd, I heard one old bystander say, "Gertie's gonna have her tumor removed." And nobody was any the wiser.

—PRESTON J. BURNHAM, M.D.

Specialist with a sideline:

He Writes Gags for TV

By Claron Oakley

● To take his mind off his practice, many a physician embraces an expensive hobby, such as orchid breeding, yachting, or photography. Not so Dr. Edward T. Tyler. *His* hobby makes money for him.

Instead of the sporophore, tiller, or camera, Dr Tyler's chosen hobby instrument is a dilapidated portable typewriter—out of which flows some of television's most widely heard and appreciated humor.

For the past nine years, this versatile Los Angeles specialist in sterility has spent several hours each week cre-

ating humor for some of the best known comedy names in TV. But his greatest claim to writing fame doubtless comes from his seven years with the Groucho Marx quiz show, "You Bet Your Life." This show consistently ranks among TV's top three in popularity; and until recently Dr. Tyler was one of the key men behind the great comedian with the shoebrush mustache.

Contestants for "You Bet Your Life" are carefully selected on the basis of personality, so that Groucho can squeeze the most laughs out of them. The network is besieged by applications from people who'd like to match wits with the razor-tongued comedian—and who also have an eye on the cash prizes (up to $1,500).

Tyler feels that the essence of Groucho's comedy is a sort of persistent cynicism. He cites, as an instance of his unrehearsed humor, the time when the comedian

AT STORY CONFERENCE, Dr. Tyler (left) and others prime Groucho Marx to torment guests on "You Bet Your Life."

took his staff to a plushy Hollywood restaurant, to talk over the script for a coming show. At the door, Groucho was stopped by the maitre d'hotel because he wasn't wearing a necktie.

Marx looked down at his tieless sport shirt and snapped: "That's just great. I could be a murderer, and if I had a tie on, you'd let me in. How do you like that? I can't eat here unless I kill somebody!"

"Please, sir," the major-domo answered, with a furtive glance at the other diners, "I have a necktie in the drawer. You can just slip it on here."

Groucho took one look at the proffered tie and shook his head. "No, thanks. It doesn't go with my eyes."

Fit to be Tied

"But, Sir," the head waiter asked tremulously, "does it really matter?"

"Certainly it matters," Groucho barked. "Did you ever see a blue eye wearing a green polka-dot tie?"

Desperate, the maitre d' slipped a striped tie instead around Groucho's neck. But the comedian kept up his running patter of abuse:

"How do you know the last man who wore this didn't have a communicable disease? Why don't you communicate with him and find out? Who makes these rules that men have to wear ties—some little guy sitting upstairs in a T-shirt?"

Finally, as the head waiter was hurrying the group through the dining room, Groucho stopped smack in the center and roared:

"Aha! You wouldn't let *me* in without a necktie, but look at *him*." He pointed with disdain at a bald-headed man enjoying an omelet. "You let *him* in without his *hair*!"

New Program

Last September, Dr. Tyler left the Groucho Marx show, in order to work on a new program tentatively called "Don't Ask Me That" (which he has already sold to a national network). But his income from the long association goes on: During the 1955 summer season, the Marx show's sponsor is running thirteen weeks of old shows called "The Best of Groucho," from which the doctor still draws rather healthy compensation.

Ed Tyler sees a fascinating parallel between medical history-taking and the spontaneous intimacy that pops up between a television writer like himself and the contestant he interviews. "A woman will bare her soul to the writer," he says. "She'll reveal things she doesn't dare tell her husband; and she'll think nothing of pouring them out to 50 million people on a coast-to-coast broadcast."

With a wry smile, he adds: "Kinsey and staff spent forty-eight man-years compiling statistics for their book. They could have got the same data from thirteen half-hour audience-participation shows. And the only cost would have been thirteen

glamorous, all-expense, five-day vacation trips."

Commenting on the current rash of quiz programs, Tyler says: "Some people may deny that these shows are educational. But where else would you learn that water swirls down South American drains in a counterclockwise direction? Or is it clockwise?

"Such shows are frothy, gay, and lilting, too," he adds.

As an example, he cites this dialogue, which he wrote for Variety, the entertainment trade publication:

A Doctor's Dialogue

M.C.: "It says on your card, Mrs. Hammerschlag, that you have an entertaining story to tell us."

Mrs. H.: "Yes. My husband has infantile paralysis and has been in an iron lung for four years. My oldest boy is suffering from arteriosclerosis and has three murmurs and hasn't been off his bed for twelve weeks. My twins have clubfeet and are Mongolian idiots. Two days ago, I was frying snails and the house burned down, so we're all sleeping in the garage. And that's why I'd like to win this all-expense vacation in Las Vegas." (TUMULTUOUS APPLAUSE)

M.C.: "Mrs. Hammerschlag, that's a very touching story, and you're a wonderful woman." (TUMULTUOUS APPLAUSE)

(At this point, the home-viewer wonders who's taking care of her paralyzed husband, her sick boy, and the two idiots in the garage.)

M.C.: "Now, Mrs. Hammerschlag, would you like to earn some money in the quiz?"

Mrs. H.: "Yeah." (TUMULTUOUS APPLAUSE)

M.C.: "O.K., we're all for you, Mrs. Hammerschlag. For $10, tell us, who was the first President of the United States? By George, you don't have to go to Washington for the answer to that!"

Mrs. H.: "Could you give me a little hint?"

M.C.: "Well, I'm sure we can give you a little one. His first name was George, and his second name began with Washing."

Mrs. H.: "Was it Martin Van Buren?" (TUMULTUOUS APPLAUSE)

M.C.: "No. That isn't right, but it's so close I'm afraid we'll have to give it to you. Now, Mrs. Hammerschlag, do you want to take your $10 and go home, or do you want to risk it and try for the $28,000 jackpot?"

Mrs. H.: "I'll try for the jackpot." (TUMULTUOUS APPLAUSE)

The Jackpot Question

M.C.: "Now, we're all behind you, Mrs. Hammerschlag. We know you need the money. And we're going to see that you get it. Now for $28,000, tell me: How many kilowatts of electricity were consumed in Smith County, Kan., during 1911?"

Mrs. H.: "Gee, it's on the tip of my tongue." [MORE ▶

M.C.: "I'm afraid the time is up. The answer is 1,934,632 kilowatts."

Mrs. H.: "I should have known that."

M.C.: "Well, better luck next time. You lost all your money; but you're not going home empty-handed. Here's a box of Crispy Crunchy Dog Biscuits to take home to that fine family of yours." (TUMULTUOUS APPLAUSE)

How He Got There

"If my case history is any criterion," Ed Tyler says, "anyone with a reasonable amount of ambition, self-confidence, and literary talent can break into TV." His "case history" goes like this:

As an undergraduate at Columbia University, he wrote a Varsity show and the humor column for the school paper. Later he helped edit the 1938 yearbook for the Long Island College of Medicine. His first attempt at professional writing was an original musical comedy called "Keep It Clean," which nearly got produced. "At least," he says, "a prominent New York night club operator was interested in it—until he lost too much money on another musical that flopped."

In 1946, the doctor moved to California, where he got his first paying job as a writer by turning out jokes for Comedian Jack Paar. From there he moved on to the Marx show, with assignments in between for the Railroad Hour, Eddie Cantor, and Joan Davis. He has been co-owner and producer of a TV series with Pinky Lee.

Today, he lives with his wife and four children in suburban Brentwood, a stone's throw from his medical offices near the campus of the University of California. He's a writer, yes; but his profession, first and always, is medicine.

Somehow, he manages to carry on extensive sterility research, as well as a busy private practice. In the past seven years, he has contributed twenty-four papers to scientific journals; and he has also presented six scientific exhibits at the annual meetings of the A.M.A.

Last year, the Association awarded him its Certificate of Merit for an exhibit of the results of a project involving shipment of thousands of specimens of semen to a research laboratory in New Jersey for chemical analysis, following clinical analysis in Los Angeles. He has found time to fill a faculty post at U.C.L.A. and to accept the medical directorship of the Los Angeles Planned Parenthood Association.

Nor is that all.

He also indulges regularly in three kinds of relaxation: golf, painting, and tennis. On occasion, for instance, he sharpens his golf score and bolsters his joke supply in a continuing tournament with Comedian Jerry Lewis, a co-member of the Brentwood Country Club.

As for his painting: "Well, he couldn't make a living at it," says his wife (an ex-art instructor). "But

he's good enough to have had his work exhibited several times; and he can hang his pictures on *my* walls any old time!"

It's in the Family

The Tylers' oldest child, 11-year-old Susanne, has already begun a journalistic career of her own. With no help from her father, she publishes a weekly neighborhood gossip sheet.

"I've great admiration for Susanne's talent," says her father. "But the product of her editorial enterprise keeps me up nights looking into California's libel laws."

In view of the money to be made in television writing, some of Ed Tyler's friends wonder why he doesn't move into the field full-time. He has an emphatic answer for them:

"With or without the money, TV writing offers a wonderful way to blow off steam. But the challenge of research and practice is the cornerstone of my life. If it came to a choice, I'd drop the writing in a minute." END

False Step

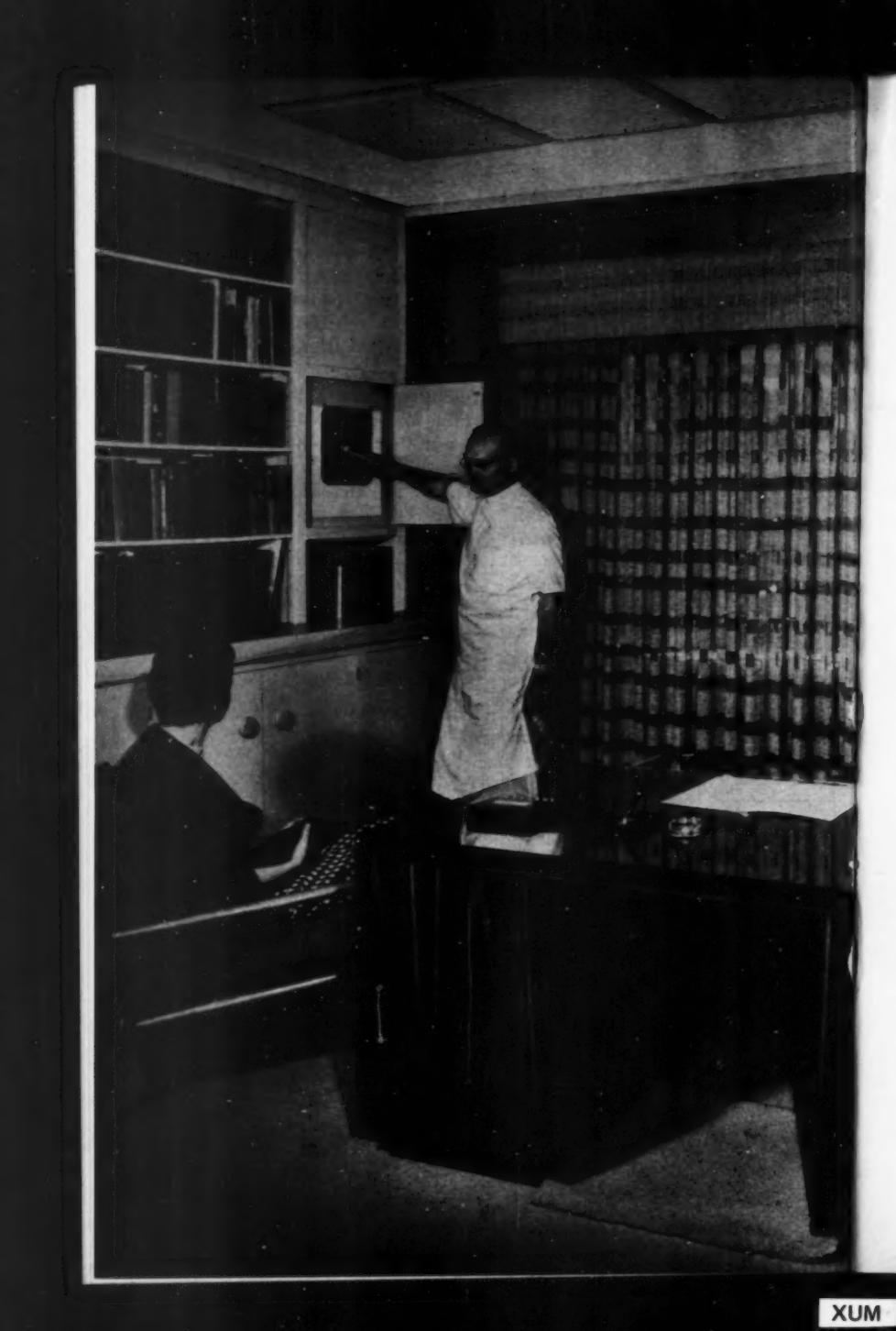
● One of my very first patients in private practice was a lumberyard worker who complained of chest pains. After a careful examination, I explained to him that the trouble might be due to his heart, even though the ECG had been reassuringly normal. So I suggested that he come back in a few days for an exercise test. Such tests, I said, often proved helpful; and I allowed him to believe that I did them all the time.

The day before he was due to return, I realized I didn't yet have the "steps" in my brand-new office. Naturally, I hurried to the nearest lumberyard for the necessary material and told the office clerk there exactly what I wanted. My description was possibly *too* exact, in fact.

The clerk whistled for one of the hired hands. "Hey!" he yelled. "There's a doctor here wants lumber for some kind of test he's going to give a guy with heart trouble."

The hired hand waited on me in courteous silence. I kept pretty quiet myself, because he was my patient.

—GORDON S. PAULSON, M.D.



Planning Paid Off In This One-Man Office

The doctor spent months perfecting scale models of every room. Result: a set-up he finds ideal

By Lois Hoffman

● Dr. M. James Whitelaw doesn't claim that his new building is the best in the country. But he does consider it the best possible building for *him*.

It's no accident that he's so well satisfied. Even before the blueprints were drawn up, the doctor knew where he wanted every last instrument drawer and light switch. What's more, he knew *why* he wanted them there.

Dr. Whitelaw's former office in downtown San Francisco had proved poorly suited to his practice in endocrinology and infertility problems. Among its drawbacks: Waiting patients could overhear conversations in the business office. Callers had to run the gantlet of the reception room, both coming and going. The examining rooms lacked good natural light. And the consultation room was too small. So he decided to build—and to build right.

As a starter, he visited a number of medical offices in the San Francisco area. From a study of their features, good and bad, he was able to draw up a list of dos and don'ts for his own building.

The list formed a basis for preliminary discussions with Architect Philip L. Coats. Then, as his next step the doctor got exact measurements of every major piece of equipment he'd need for the new office.

These measurements helped the architect work out

scale models of all rooms, complete with furnishings. Not only was Dr. Whitelaw able to decide how he wanted each room arranged, but he reshuffled the models themselves until he was satisfied with the entire layout.

Next, an engineer from the local power company gave expert advice on illumination problems. Then—and only then—the architect got to work at his drawing board.

At that point, Dr. Whitelaw began hunting for a suitable lot (a reversal of the usual tendency to design a building to fit the ground it will go on). It took a while; but he eventually found what he wanted on the outskirts of San Jose, about an hour's drive from San Francisco (where he still has consultations once a week).

"This advance planning—as well as the purchase of new equipment, checking up on construction, and so on—took me several hours a week, for the better part of a year," he says. "But it was worth-while, every minute of it."

In the eleven months since moving into his new quarters, Dr. Whitelaw has become aware of only one minor drawback: The marbleized white vinyl tile covering used on some floors shows the dirt too easily.

Five major problems common to all types of medical practice were solved during the planning stage of the project. Pictures and text on the following pages show what they were—and how they were met.

PROBLEM: How to provide plenty of light, both natural and artificial.

SOLUTION: The lighting engineer specified northern skylights of wire glass (with diffusion glass below) in the two examining rooms. Thus, there are almost no annoying shadows; and the doctor can judge true skin color in cases where it's important. Fluorescent tubes above the diffusion glass light these rooms on dull days.

There's another small skylight in the so-called "solar-

ium" (above the sofa) in the reception room. The large window facing the street has a pull-up slatted shade; this, as well as the roof overhang outside, keeps out most direct sunlight.

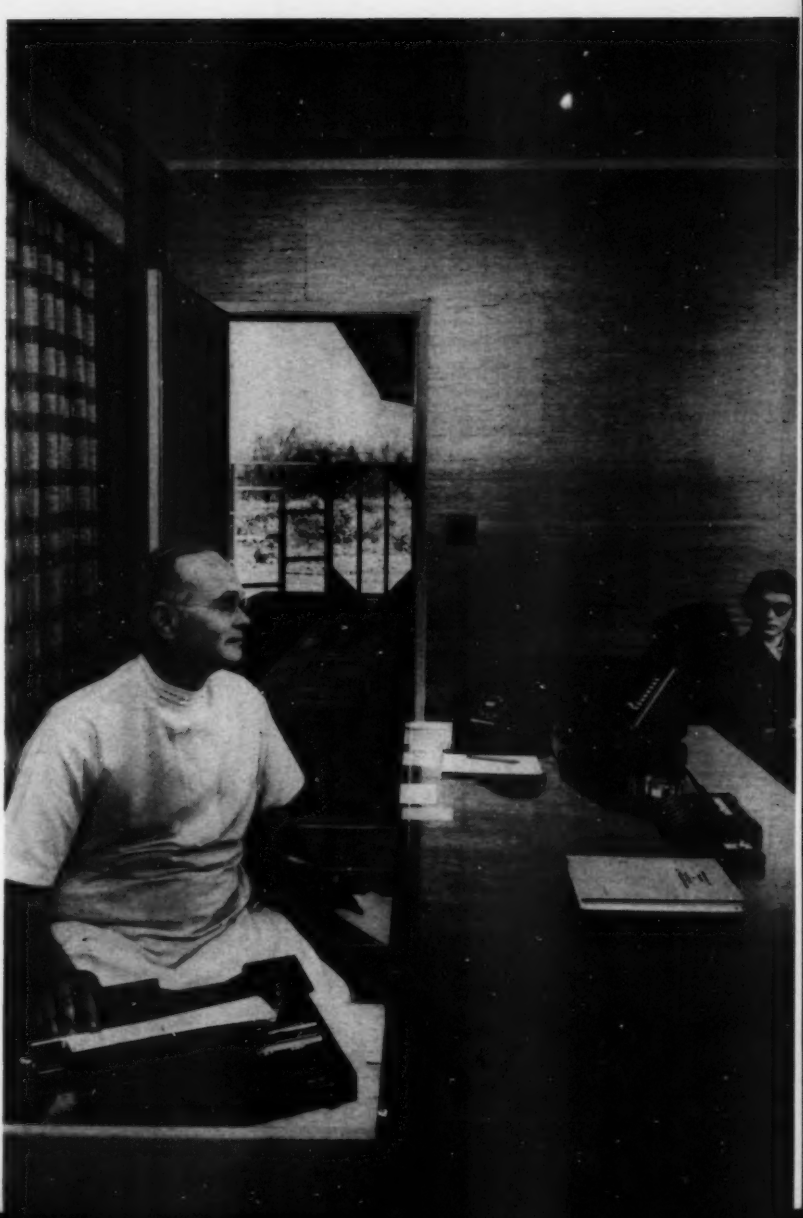
Ceiling fixtures are covered with translucent plastic shades. These do a good job of diffusing the light.

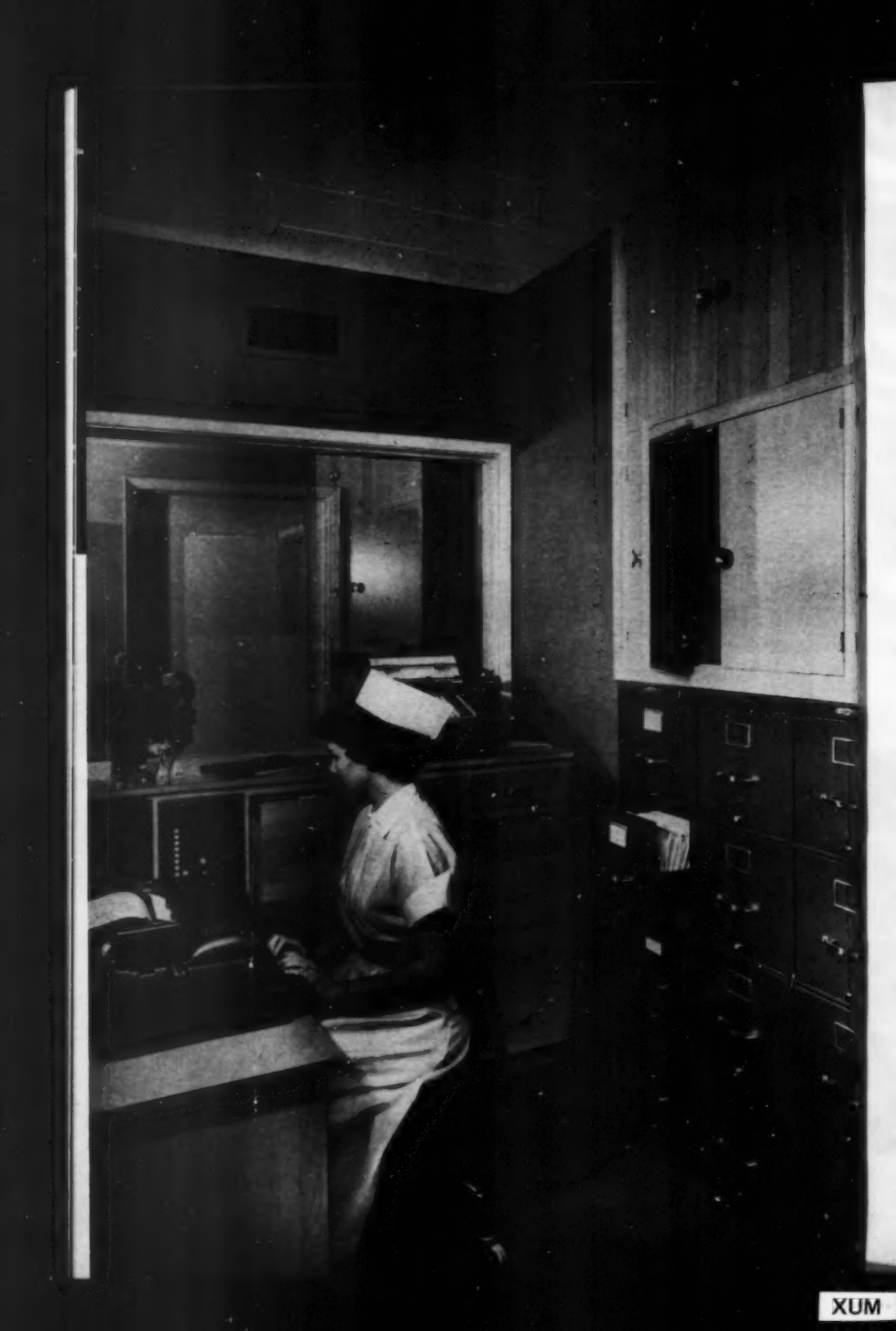
PROBLEM: How to arrange the office so that records can be kept completely up-to-date.

SOLUTION: With the help of an intercom system and two typewriters, consultations and examinations are recorded as they take place. Here's how the system works:

In the consultation room, Dr. Whitelaw takes down the patient's history on a portable typewriter, making two carbon copies. (Patients, he says, don't find this method too distracting.) Then, when the nurse comes to show the patient into an examining room, the doctor hands her the typescript.

She takes it back to the business office, inserts new sheets in her typewriter, and sets the intercom so she can hear conversations in the examining room through an





earphone. The doctor then dictates his findings as he goes along (omitting possibly alarming details, which he fills in later). The intercom station picks up his voice from anywhere in the room.

This system saves him and the aide a good deal of time, the doctor feels. And the patient, he adds, is spared possible embarrassment at having a third person present during the examination.

When the exam is over, the doctor uses the intercom to brief the aide on any left-out details or on any special procedures that need to be scheduled for the patient's next visit. By the time he returns to the consultation room, the completed case history is supposed to be in his top desk drawer. Often he can mail a referral report the same day he sees the patient.

Bookkeeping is simplified by the use of a billing machine that makes two itemized copies of the patient's account: one for the master file, one for the monthly statement.

PROBLEM: How to give the patient maximum privacy.

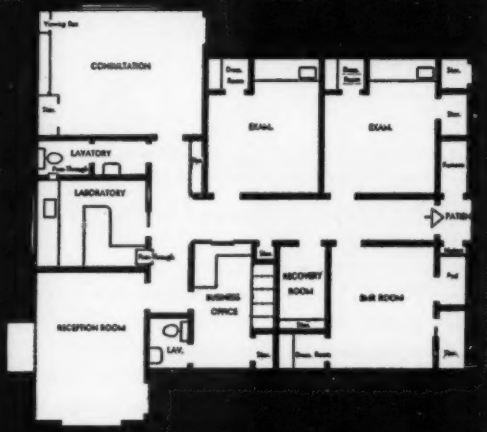
SOLUTION: Virtually all views from outside the building are barred by shades, louvers, translucent glass, and a fence off the parking lot. And once inside, the patient rarely sees anyone but the doctor and his aides. [MORE ▶

This is possible because, for one thing, a T-shaped corridor separates the treatment area from the rest of the office. From the reception room, the newcomer goes along the crossbar of the T to the consultation room or, perhaps, the lavatory. Then the nurse escorts him to an examining room around the corner (see floor plan at right).

When he's ready to leave, he can discuss appointments and payment with the aide at the business-office window in the hall. (Note that the business office is isolated from all other rooms, including the reception room.) The patient then goes out by the side door.

Another contribution to privacy: Heavy felt and spun glass were used to soundproof the walls; and acoustical tile soundproofs the ceilings.

To cut down even further on unnecessary noise, lights (rather than a bell) signal each new arrival. When the front door opens, tiny wall lights in the business office, hall, examining rooms, and BMR room go on for one minute. All toilets are the silent-flushing type.



◀ **PROBLEM: How to store supplies conveniently and make the best possible use of floor space.**

SOLUTION: Built-in instrument cabinets are convenient to each examining table. Filing cabinets in the business office are likewise within easy reach of the aide.

An L-shaped counter gives ample, efficiently placed drawer- and work-space in the small laboratory. (Note that there are four electrical outlets in the counter top.) Revolving shelves behind the large cabinet door at the right make small bottles and boxes quickly available to the technician.

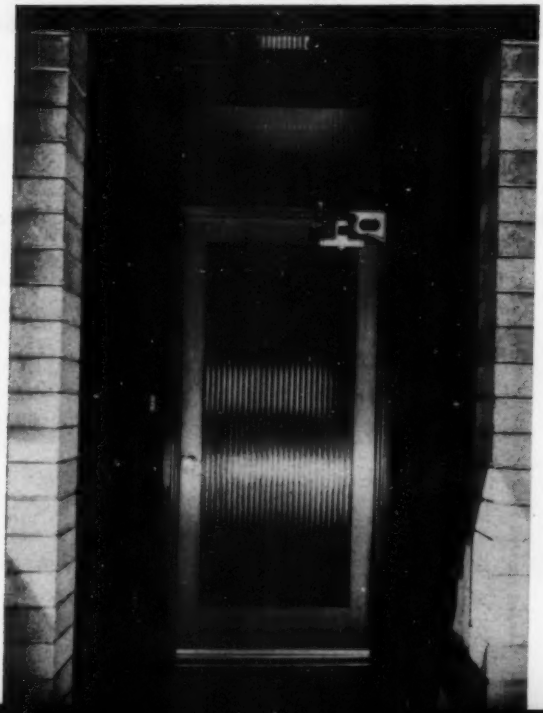
Example of how floor space can be made to do double duty: The BMR room can be converted into a third ex-

amining room when the Murphy bed is folded into the closet. (Note that the base of the scales is set in the floor, to prevent tripping.)

PROBLEM: How to keep building maintenance—deliveries, repairs, etc.—from interfering with office routine.

SOLUTION: Repairmen and other such workers need seldom enter the building. Reason: Outside closets—one housing the furnace and water heater, the other for gas and electric meters—flank the patients' exit. Still another outside closet holds garden tools and rubbish cans. There's a mail slot under the business-office window in front.

All inside maintenance facilities are located in the hall. Telephone and intercom panels, for instance, occupy the lower part of a closet, which also contains laboratory and



business supplies. Across the way there's a pass-through for deliveries of distilled water. A linen closet and laundry chute are around the corner by the aide's window.

One final convenience: The last person out in the evening doesn't have to wander all over the office to turn off lights. A delayed-action master switch, which gives him time to reach his car first, does the job. END

G. P. Hospital Rejects Blue Cross

Charging that the plan is 'allied with specialist groups,' these family doctors have voted to cancel their hospital's membership

By Thomas Owens

● In the recurrent G.P.-hospital dispute, general practitioners have usually aimed their fire at "accreditation-conscious" administrators and at "specialist-ruled" staffs. Now a handful of Chicago G.P.s have charged that still a third party, Blue Cross, is aiding the opposition.

The charge was made by the medical staff (all G.P.s) of Kenner Hospital in Chicago, when the institution—a Blue Cross member since 1950—announced its withdrawal from the plan.

Kenner Hospital and Chicago's Blue Cross plan had been feuding privately for several months. According to Blue Cross, the trouble started originally when the hospital was asked to refund to the plan $16,000 in "overcharges" for care of subscribers during the 1953 fiscal year.

(Under its contract with member institutions, the plan pays hospitals their established daily rates with this proviso: If a year-end audit shows that the hospital's income has exceeded its operating costs by more than a predetermined percentage, it will refund a portion of the difference to Blue Cross.)

Dr. William H. Kenner, director of the 65 bed, non-

profit hospital, denied that the request for the refund (or "kickback," as he termed it) had moved the staff to cancel its Blue Cross membership. The real reason for the hospital's withdrawal, he claimed, was that "Blue Cross doesn't work for the ultimate good of the general practitioner, the hospital, or . . . the general public." The doctor amplified this statement in a number of charges. Here's a condensed version of them, together with the plan's rebuttal:

The charge: Blue Cross allows itself to be used as a tool in the hands of specialist groups who seek to bar the general practitioner from the nation's hospitals. For instance, the plan admits as member-hospitals only those accredited by the Joint Commission on Accreditation, which is dominated by the American College of Surgeons. But insurance companies don't demand accreditation before paying the hospital bill—so why should Blue Cross? [Kenner Hospital is provisionally accredited.]

The reply: Blue Cross is not an insurance company but a health plan. It admits only accredited hospitals as members so as to make sure that patients get the best care available. And claims of a Blue Cross "alliance with specialist groups" are groundless: Blue Cross does not concern itself with the practice of medicine as it affects the general practitioner or specialist.

The charge: Blue Cross interferes with free choice of physician and hospital. It doesn't explain to subscribers that many of its member-hospitals severely limit the privileges they give to family doctors. As a result, many patients don't realize that to get the full benefits guaranteed in their contract, they may have to say good-by to their family doctor at the hospital door and then start paying specialist fees.

Neither does it explain that if the patient decides to be treated in a non-Blue Cross hospital, the plan will pay only a fraction of the daily cost. [MORE ON 240]

Polio Post-Mortem: W

This incisive report cuts through the months of confusion and lays bare the hidden causes. What did the Polio Foundation do wrong? How much to blame were (clockwise) Dr. Jonas E. Salk, Dr. Hart E. Van Riper, Dr. Leonard A. Scheele, and Basil O'Connor? Here are straight answers

● Dr. Milford O. Rouse, an eloquent Texan, summed it up best, perhaps, when he told the A.M.A. House of Delegates, meeting in Atlantic City a couple of months ago:

"A perfectly fine ultimate goal was thrown into confusion and disorder because we did not let evolution take its natural course."

He was referring, of course, to the way the news of the Salk vaccine field trials had been flashed to a waiting world—how the headlines had changed from rosy pink to a doubtful gray as the mass immunization program against poliomyelitis waxed, wobbled, and waned.

From the tallest towers of medicine down to the doctor's office over the village bank, there has been agreement on at least one thing: Physicians have likened the

em: What Really Happened

By Greer Williams

April 12, 1955, announcement in Ann Arbor to a "circus," a "Hollywood première," a "TV spectacular."

The journal GP has accused the National Foundation for Infantile Paralysis of arranging "to wring the last ounce of drama and sensationalism out of the event." Northwest Medicine has spoken bitterly of "mass application . . . and near hysteria." And so on.

An unnamed California physician may have given the general feeling its most striking expression in the following rich mixture of indignation and fine phrasing:

"I doubt that there has been another development in medical science heralded with such atrophy of reason and misuse of rhetoric . . . By comparison, a cure for cancer should throw the public into such a protracted, horn-blowing, blubbering tizzy as to threaten total extinction of our waning art of conversation . . . It was a unique and distasteful experience in my medical career to wait, shoulder to shoulder with a frenzied public, for an announcement concerning a development in my own professional field . . ."

[MORE▶

Texas and Massachusetts brought resolutions of protest before the A.M.A. House of Delegates. "Undue fanfare," they charged, had "violated traditional methods by which investigators. . . announce and critically review discoveries and applications thereof." They deplored "the lack of reliable information . . . given the medical profession by the Federal Government and the National Foundation . . ."

Nobody is mad at Jonas E. Salk. Everyone agrees with Dr. Elmer Hess' description of him as "a modest young research physician" who gave his vaccine to humanity and passed up a chance to be a multimillionaire. But countless M.D.s have expressed resentment against the lay organization financing his work. Among the most frequently heard complaints are these:

'M.D. Wasn't Informed'

1. *The N.F.I.P. bypassed private physicians.* The nation's doctors had no chance to learn about the vaccine before their phones began to ring. As one close observer puts it: "It was that old irritation at having to read about medicine in the Reader's Digest in order to keep up with your patients."

2. *The A.M.A. was snubbed, too.* Its Board of Trustees had offered the N.F.I.P. a three-man committee to evaluate utilization of the Salk vaccine; but the offer had been turned down. Later, when invited to co-sponsor the closed-circuit TV broadcast to doctors put on by Eli Lilly & Co. on the night of April 12, the A.M.A. asked for a prior look at the Francis report. The request was refused.

3. *Doctors were given no time for study and reflection.* The vaccine had been stockpiled before Dr. Thomas Francis Jr. reported how good it was; it was licensed on the day he revealed his findings; and it was immediately placed in general distribution. It seemed a foregone conclusion that mass production of the vaccine was safe and effective—and that medical men needed to know nothing more.

The Supply Problem

4. *The promised fair distribution did not materialize.* The Foundation had announced that 9 million school children would have priority, but that "a very substantial supply of vaccine will be available to physicians through normal channels." With Cutter Laboratories the first to make a large-scale shipment for private use, only about 10 per cent of all vaccine was distributed commercially up to May 8, when the Public Health Service called a temporary halt to the immunization program.

5. *The Ann Arbor announcement was scheduled on the tenth anniversary of Franklin D. Roosevelt's death.* This made many Republicans hit the ceiling. They refused to believe that the issuance of the announcement on the Roosevelt anniversary might have been coinciden-

OPENING NIGHT atmosphere that surrounded the release of the Francis Report is evidenced by this glimpse of Dr. Salk amid a battery of TV cameras.

tal. For their money it was just what one of them had called it: "cheap exploitation."

What does the Polio Foundation say to all this?

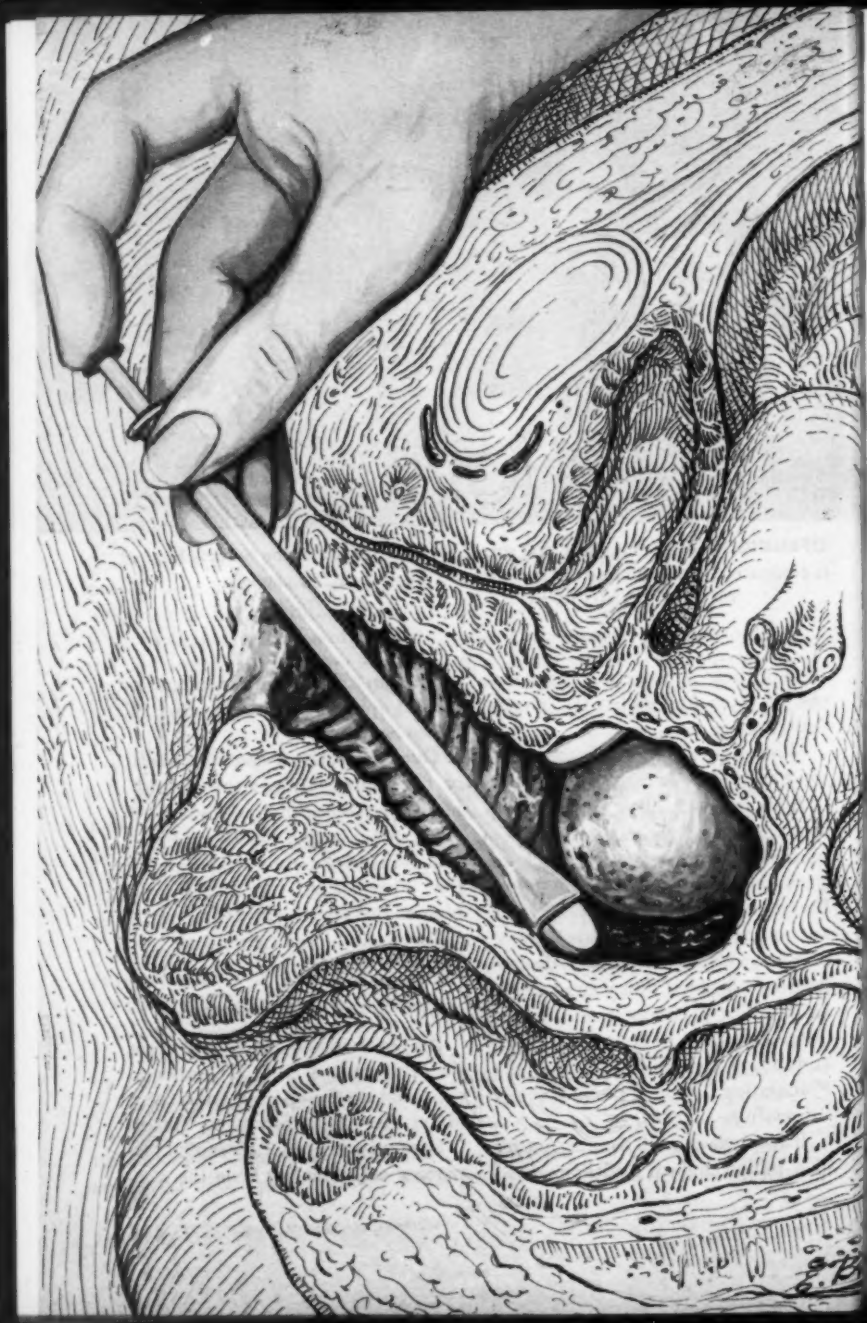
It's not, first of all, an organization that can be lightly dismissed or pushed around, simply because some people object to its methods. Founded in 1938, the N.F.I.P. was an outgrowth, as everyone knows, of Roosevelt's interest in a disease that had disabled him years before. In its effort to assure polio victims of medical care, to finance research, and to keep the public informed, the Foundation has been phenomenally successful.

It has raised more than a quarter of a billion dollars; and it invested more than $25 million in fundamental and applied research leading up to the Salk vaccine.

Over the years, a certain amount of resentment toward the N.F.I.P. has been voiced by persons interested in far bigger health problems that get far less public attention. But the Foundation can hardly be blamed because the fear of paralytic polio has an obvious emotional grip on the nation's parents.

O'Connor Comments

To get an idea of its point of view, I recently asked Basil O'Connor to comment on the doctors' complaints about the organization he heads. O'Connor, who was Roosevelt's law partner and who has been the non-



FLORAQUIN VAGINITIS REGIMEN

New Intravaginal Applicator for Improved Treatment of Vaginitis

The restorative treatment of vaginitis with Floraquin is now further improved by a new aid to tablet insertion. Faulty insertion is no longer a failure factor in therapy.

The new Floraquin applicator is designed for simplified insertion of Floraquin tablets by the patient. This plunger device, made of smooth unbreakable plastic, places the Floraquin tablets in the fornices and thus assures coating of the entire vaginal mucosa as tablets disintegrate. The patient inserts two Floraquin tablets with the applicator in the morning and also two tablets at night, with treatment being continued through at least two menstrual periods. During menstruation it is desirable to increase medication to eight Floraquin tablets daily to combat the greatly increased alkalinity of the menstrual flow.

Treatment with Floraquin tablets may be supplemented with insufflation of Floraquin powder by the physician. Frequency of insufflation is determined by the physician, but is of prime importance immediately after the first menstrual period.

Warm acid douches (2 ounces of 5 per cent acetic acid or white vinegar to 2 quarts of warm water) may be taken as often as desired for hygienic purposes.

Floraquin contains Diodoquin® (diiodohydroxyquinoline, U.S.P.), the safe and effective protozoacide and fungicide. Lactose, anhydrous dextrose and boric acid are included to help restore the normal acid pH of the vaginal secretions. Such an acid vaginal medium then encourages the growth of normal flora and makes the environment unfavorable for pathogens.

A Floraquin applicator is supplied with each box of 50 (a new package size) Floraquin tablets. G. D. Searle & Co., Research in the Service of Medicine.

SEARLE

salaried president of N.F.I.P. since it began, replied with sweeping bluntness.

"Doctors," he said, "are human beings, and just about as stupid as the rest of us. They don't think things through. Of course, not knowing what we're talking about is a general human failing. They complain of 'undue fanfare'? Well, ask them what they mean by 'fan' and what they mean by 'fare.'"

To understand the medical profession's reaction, he added, it's important to realize that "the American Medical Association is jealous of any invasion of its prerogatives. It feels it has a prior right in anything relating to disease or health of the people.

"The American Bar Association would behave much the same in matters of law. But the fact remains that medicine and law are in the public domain."

Why, I asked, was there such a rush to get into production before the vaccine was licensed?

"There was no great hurry," said O'Connor. "It took nine months to evaluate the field trials. I suppose we could have found some man to do it in thirty days, but we wanted the best scientific brains we could get."

The Public's Stake

He did not belong, he explained, to "the standstill school." The public has a stake in the polio vaccine; and so "we had the moral responsibility

to prevent some polio this year. You have to give the public what you have, knowing it *could* be better but that it will do some good now.

O'Connor's Gamble

"The manufacturers were going to quit making vaccine after the 1954 trials began," he went on. "They said they couldn't stockpile it against a gamble. I didn't know what was in the Francis report until 8:30 on the morning of April 12; but back in '54 we knew the Salk vaccine would work. So I asked the manufacturers how much they could produce by the first of the year. They said about 27 million cc.s. We bargained with them, got a nice contract—and took the gamble."

O'Connor's point, then, seemed to be that the N.F.I.P. had taken a calculated risk of about $9 million in production costs so that polio immunization might move from the experimental to the clinical stage without interruption. The production facilities of May, 1954, seemed just too valuable to be abandoned. *Had* they been, no vaccine would have been available for mass immunization in 1955. As it was, the manufacturers were encouraged to speculate a little themselves; so they increased their production even more.

All this was done openly, say

Foundation officials. Dr. Hart E. Van Riper, N.F.I.P. medical director, insists that 180,000 doctors were fully informed of the situation by direct mail in "Report to Physicians" letters in October, 1954, and March, 1955. The latter message, setting April 12 as the date for the Ann Arbor announcement, enclosed two Salk reprints. Then, on the big day, the Francis report was delivered over a one-hour telecast to 40,000 physicians in fifty-one cities.

What about another complaint of the doctors—that there wasn't enough scientific presentation and publication of the facts?

Dr. Van Riper, defending the N.F.I.P. at an A.M.A. reference committee hearing in Atlantic City, maintained that the Ann Arbor assembly had been a scientific meeting. As far as the release of texts to the press went, he said, this constituted no departure from accepted public relations practice at most medical meetings, including the A.M.A.'s.

No Criticism of Salk

As I've pointed out, medical men in general have been fairly careful to fish Jonas Salk out of the muddied waters—and rightly, for he has handled himself well under trying circumstances. "My function, my job," he says, "is that of an investigator. I present and publish ma-

terial. Others say, 'Let's put it into application.'"

But Salk is, frankly, unhappy that he may be accused of having neglected scientific publication. In an interview with him, I mentioned that some doctors thought everything about the vaccine should have been published in the Journal A.M.A., where it could have been read by the whole medical profession. "Don't think that wasn't obvious to me, too," he answered.

The Polio Papers

He then referred to a series of ten papers on his work published between March, 1953, and May, 1955. The first, dealing with the initial 161 of the 14,000 human subjects on whom he tried his vaccine, appeared in the J.A.M.A. Most of the other papers were printed in the journal of the American Public Health Association.

Salk admits that the number of doctors who read the public health journal is small. But he also points out that he offered two papers on polio to the J.A.M.A. in 1954 and that both were rejected as "too technical" or as "adding nothing new" to the subject.

(Dr. Austin Smith, J.A.M.A. editor, confirms these facts. The Journal, he explains, seeks to publish information of the widest possible clinical interest; and this means

practical material in capsule form.)

The N.F.I.P. rebuttal to the doctors' charges also includes an explanation of why the A.M.A. offer of a committee to evaluate the vaccine was rejected: Pointing out that the Foundation had divorced itself from the evaluation and had left it to Dr. Francis, an independent investigator, Van Riper told the Atlantic City meeting that Francis had objected to the presence on the proposed committee of Dr. Albert B. Sabin. Dr. Sabin, who is developing a competitive attenuated-virus vaccine, was on record that the killed-virus vaccine would not work; his evaluation could hardly have been deemed impartial. Anyway, asked Van Riper, what was the need of evaluating the evaluator?

In addition, he sought to explain the matter of timing the Ann Arbor announcement on the tenth anniversary of F.D.R.'s death: "I'll never be able to convince anyone," he said, "but the date was pure happenstance." April 12, he said, was the day that most nearly met both TV programming needs and Dr. Francis' target date.

The Two Snags

Foundation officials say their program would have survived 1955 with a clean bill of health except for two things: (1) the Cutter incident and (2) the inclina- [MORE ON 215]

Myths About Admissions To Medical School

Does your son think he needs a science major and a nod from the 'right' college? This article gives the lie to many such half-truths

By John R. Lindsey

● "Boy, what a rat race!"

You may have used those words once—back in the days when you were an anxiety-ridden premed student, trying to get into medical school. And you may hear them again —if you haven't already.

The point is: When you're asked questions by your son —or your neighbor's son—who wants to follow in your professional footsteps, what can you tell him? Do *you* know what's actually required for admission to medical school today?

The men who draw up the entrance requirements have news for you. Dr. Lowell T. Coggeshall of the medical school of the University of Chicago says, "Above all, we are seeking well-rounded men who possess an unquestioned motivation to study medicine." Dr. Daniel H. Funkenstein of the Harvard Medical School agrees; he says the ideal candidate is "the mature, broadly educated man of integrity" whose training has emphasized human relations and human understanding.

But, as Dr. Funkenstein admits, that's not an easy idea to get across to the undergraduate and his advisers. There's a fog of misunderstanding in the way. [MORE▶

He quotes the Harvard Crimson as saying: "Premeds are a special breed . . . who talk ceaselessly about the last Chem 20 exam at breakfast, and who gather in little worried groups to discuss chances of acceptance at medical school . . . Wild rumors sweep through the ranks of premeds, leaving pale faces and young neuroses in their wake."

Why the worry? Dr. Funkenstein, a clinical associate in psychiatry at the university, says it stems from a number of widely accepted myths about medical school admissions. In the Harvard Alumni Medical Bulletin recently, he punctured some of these myths.

What he has to say applies, naturally, only to the Harvard Medical School. But his remarks suggest that Harvard's policy differs little from that at most other schools.

Dr. Funkenstein confronts each of the myths (paraphrased below) with the facts to disprove it. Therein are some specific answers for your son and his friends.

Myth: The premedical student must have come from the "right" state, to be sure of admission on a geographical basis.

Fact: At Harvard, at least, there is no geographical quota. In the last four years, forty-two states have been represented in the medical student body there. And, as might be expected where no quotas exist, the

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REFERENCE: 1. Kirwin, T. J., Lowsley, O. S., and Menning, J., Am. J. Surg. 62:330-335, December 1943.

more populous states have supplied the greatest number of students.

Myth: He must have gone to the "right" college.

Fact: On the average, some forty-eight different colleges were represented in each of five recent medical classes entering Harvard. From 1940 to 1950, 219 different institutions were represented.

Myth: The premedical student must have majored in science.

Fact: Nine per cent of the science majors and 12 per cent of the non-science majors who applied for places in the medical class that entered Harvard last fall were admitted. "Unfortunately," writes Funkenstein, "the great majority of applicants *had* majored in the sciences." So the admissions committee "was forced to select a majority of the class from this group."

Of course, he adds, "it would have been grossly unfair to have rejected a large number of men because of their overspecialization in science." But the committee "looked askance" at men who had studied science "at the expense of a broad education."

His conclusion: Medical schools want men of all-around ability—not men who study science only because they think they ought to.

Myth: The applicant must have made an extremely high score on the Medical College Admission Test.

Fact: The average score of the Harvard medical students admitted last year was at the eighty-fourth percentile of all medical school applicants. It's none the less true, says Dr. Funkenstein, that 60 per cent of these youngsters—and 79 per cent of those who entered in 1953—were below the sixty-ninth percentile on at least one part of the four-part test.

Myth: An A average in college is a must.

Fact: The average undergraduate grades of the 228 members of the classes of 1957 and 1958 at the Harvard Medical School may be seen in the accompanying table. "The average grades *are* high," says the doctor; but he points out that students with a B average or less made up 20 per cent of the total admitted.

Average Undergraduate Grades*

Percentage Of Students	Average Grade
6	A
44	A–
30	B+
6	B
13	B–
1	C+

*Harvard Medical School classes of 1957 and 1958.

Grades, Dr. Funkenstein maintains, are by no means the [MORE ON 235]

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Haddy, T. B., and Adams, F. H.: J. Pediat. *40*:243 (Feb.) 1952.

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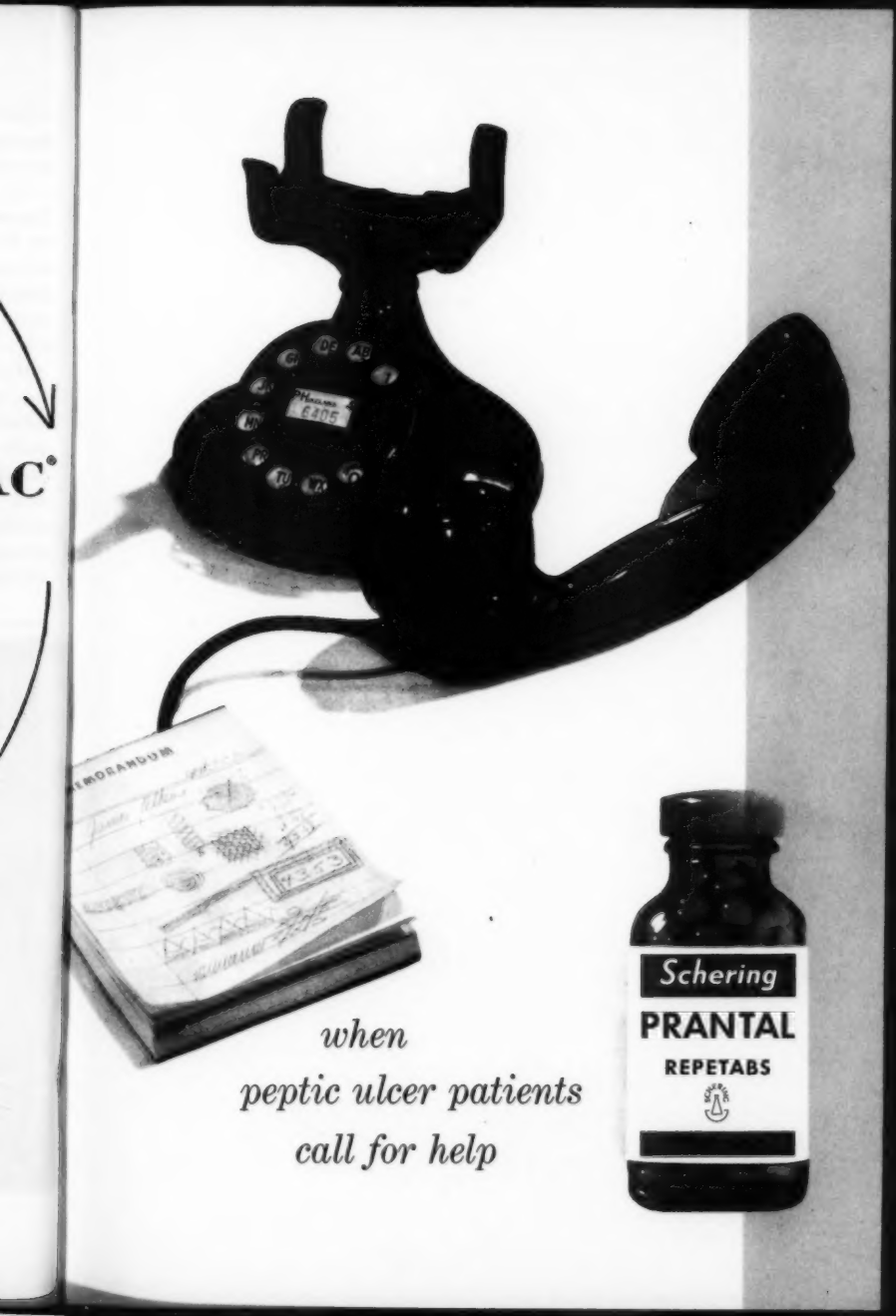

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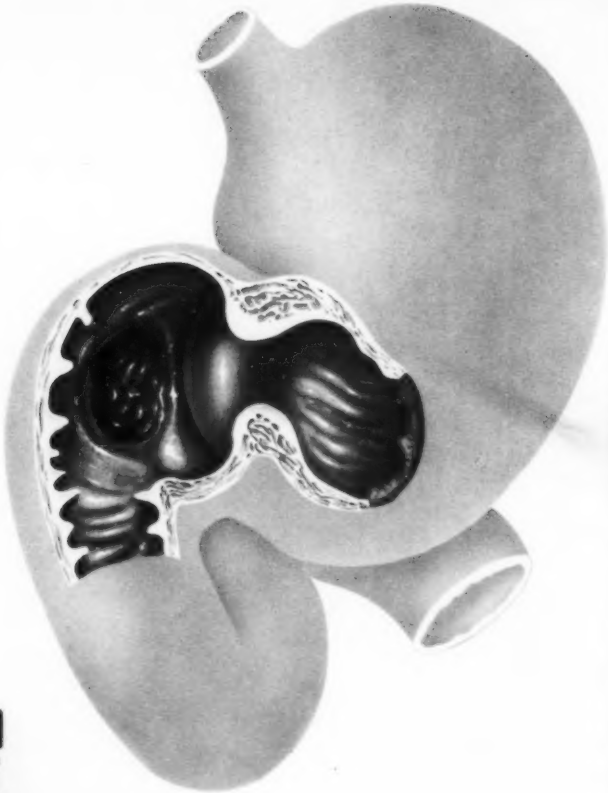

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Rx Errors Like These Can Lead You to Court

Incomplete Rx's, rather than incorrect ones, cause most of the court cases against prescribing physicians. Here are some examples of prescriptions reflecting 'lack of due care'

By G. I. Swetlow, M.D., LL.B., and J. M. Leitner, LL.B.

● Some years ago, an Illinois physician wrote a prescription for a baby six months old. Several days later, the baby died—and the physician found he was facing a $50,000 malpractice suit.

His prescription had called for *Tr. opii pulv.* What he'd meant to prescribe was *Tr. opii Camph.* His slip was held to be the cause of the child's death, regardless of the pharmacist's failure to catch the error. The fact that the pharmacist did not check with the prescribing doctor, ruled the court, did not absolve the medical man from liability.

This is just one instance of the law's attitude toward a physician who writes a prescription that causes death or injury. Remember that once issued, a prescription passes beyond the control of the prescribing M.D. If there is anything wrong with it, it gets a permanent place as evidence against him. And the courts don't take such evidence lightly.

[MORE ▶

DR. SWETLOW is a professor of medical jurisprudence at New York's Brooklyn Law School. Mr. Leitner is a member of the New York Bar.

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You might expect incorrect prescriptions to be the main source of trouble. But you'd be wrong. Incomplete prescriptions, or misunderstood ones, crop up more frequently in court. For example, illegible prescriptions have set off many a malpractice case.

Take the Missouri medical man who wrote an Rx for "10 grams" of a certain drug. The druggist thought it said "10 grains." When the case came to trial, the physician defended himself by claiming that the pharmacist had no right to guess the dosage. But the court ruled that the M.D. couldn't duck responsibility for the error. His prescription *was* hard to read, the court held.

Another legal land mine is the prescription reading *Sig: As directed.* If a patient misinterprets the doctor's accompanying oral instructions, and if his health is damaged thereby, can the doctor be held liable? Answer: He can.

As one court put it: "Failure to write out instructions clearly may itself be construed as negligence."

Consider the case of a Kansas practitioner who told his patient to take one teaspoonful of the prescribed drug every four hours. Instead, she took four teaspoonfuls every hour.

When disastrous results followed, she sued the M.D. Since the Rx did not specify dosage, it was his word against hers. A jury accepted the patient's version, and the doctor was held liable for $10,000 in damages.

Failing to write in the age of the patient constitutes another trap. This is especially true in prescribing

"Gentlemen, do you mind if I play through? I just heard my wife has been taken seriously ill."

for children. If a druggist fills such an Rx, calling for what amounts to an overdosage, *he* may be in the clear—but the physician won't.

I remember one case where a doctor prescribed 1-gram tablets (instead of quarter-gram tablets) of an antibiotic for a 3-year-old child. As a result, the child died. The druggist testified that the dosage was normal for an adult, and that he had no idea the Rx was intended for a child. The doctor hadn't noted it on his prescription. So the doctor was the one who took the rap.

The telephoned prescription also leads frequently to court. It's dangerous because, over the phone, so many terms are easily confused. Perhaps you remember the case of the Vermont physician who, prescribing for mosquito bites, telephoned a druggist and requested "mild chloride of mercury." The druggist gave the patient *bi*chloride of mercury.

A jury found against the doctor, not against the pharmacist. Commented the court: "The mere fact that a physician entrusts a prescription to something as ephemeral and easily confused as a spoken order might well stamp him as negligent."

Dispenser's Responsibility

You may be wondering at this point: "Doesn't the *dispenser* of a prescription have any responsibility?" Of course he does. The law

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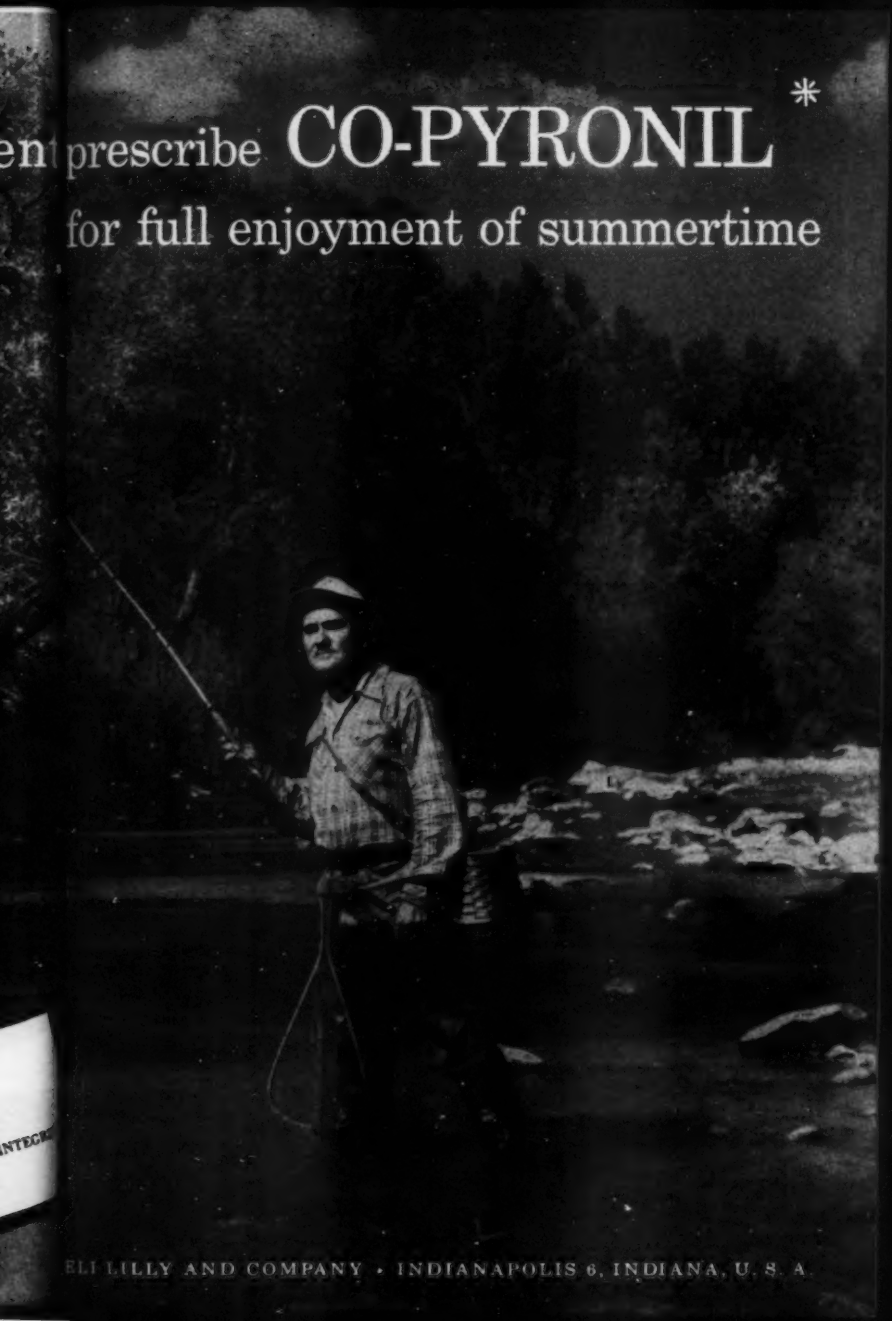
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For example, a Georgia physician prescribed a 1 per cent solution of gentian violet, to be used as a mouthwash. He told the patient that it could also be used as an eyewash. But the pharmacist who filled the Rx delivered a 3 per cent solution.

The patient lost her sight and sued the pharmacist. In court, the druggist tried to blame the prescriber. He argued that the Rx called for a mouthwash, not an eyewash; and that the preparation delivered was harmless if so used.

But the court ruled that the druggist was responsible for breach of guarantee. The patient collected from him.

Even if a drug is wrongly labeled by the supplier, the dispensing druggist or M.D. is held responsible under breach of guarantee. But in this case, the dispenser may sue the supplier on the same grounds and, as a rule, recover damages.

The basic rule governing prescriptions is this: Both the physician and the pharmacist are required to exercise "due care." And "due care" is measured in terms of the dangers that "can reasonably be anticipated to flow from a mishap."

That's why erroneous Rx's are by no means the only mishap a prescriber may be held accountable for. Unclear prescriptions produce equally great dangers. Better write yours with this in mind. END

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A Psychiatrist Answers His Critics

Does it seem to you that psychiatrists charge too much, spend too much time with patients they can't help anyway, and in general make things difficult for their medical colleagues? Then this doctor has some news for you

By Don D. Jackson, M.D.

● As a psychiatrist practicing in a large medical group, I constantly have to explain and defend my specialty. Sure, my colleagues believe in psychiatry—otherwise they wouldn't have me in the group. But I sometimes feel more like an in-law than a blood relation.

For example, when one of the other men refers a patient to me, he's likely to do so rather hesitantly. There's an awkwardness in his manner that wouldn't exist if he were referring the case to any other type of specialist. And I can guess what's on his mind: "My patients are likely to be offended when I suggest that they need a psychiatrist."

Yes, some patients are. Yet a large number of my most treatable patients come of their own accord—and often over the protests of their doctors. Obviously, there's more to the problem than the *patient's* attitude.

Part of the problem, it seems to me, is that the medical profession at large doesn't entirely understand psychia-

THE AUTHOR *is senior psychiatrist at the Palo Alto Clinic, Palo Alto, Calif.*

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.rists. What is needed is better communication. So I'd like to do what I can to clear the wires.

Here, then, are one psychiatrist's answers to a few of the questions that other physicians are constantly asking:

Too Hard to Reach

1. *Why is the psychiatrist's schedule so rigidly adhered to; and why can't he be interrupted when he's with a patient, like the rest of us? Such intransigence makes it difficult to arrange referrals.*

The psychiatrist has to handle phone calls between patients because an interruption can be inhibiting to the person he's trying to help. We've learned that it takes from forty-five minutes to an hour to get a patient talking freely about himself. And we have to fit seven to nine such interviews into the working day.

That's why we have to allot our time more carefully than most other M.D.s. We rarely see a patient who can be handled in a few minutes; and so there's no flexibility to allow for "walk-ins."

2. *Isn't it uneconomical and unnecessary to see the ordinary neurotic for an hour? Wouldn't many such individuals benefit from a good kick in the pants; and aren't others simply biologically inferior?*

Most of our patients have already had the "kick-in-the-pants" treatment from others, or even from themselves. And it hasn't worked. Remember that the psychiatrist doesn't merely give reassurance; he tries to understand another human being's total life situation. And he can't get to the heart of the matter in a few minutes.

Nor is it enough to think in terms of "biological inferiority." The more we learn of human behavior, the more we realize that constitution and heredity play a minor role. Even in the animal world, behavior is more than a simple matter of inborn possibilities. For example, psychologists have recently discovered that the environment of rats—how they're petted, cuddled, and so on—has much to do with their ability to run a maze.

3. *Why, as the patient's physician, am I not often in a better position than the psychiatrist to advise him with his emotional problems?*

In many cases, the family doctor *is* the logical counselor. But advice is a very small part of the psychiatrist's function. It's less a question of telling someone what to do than of helping him find out what he *wants* to do. This takes some understanding of the function of the unconscious, the use of psychic defenses, and such.

Some years ago, the typical doctor could do much less *medically* for his patient than he can now. So a major part of his function was as family counselor and father confessor. Today, he's so busy keeping up with blood chemistry, isotopes, and the latest vaccine that he has little

time for people's emotional problems.

Then, too, it takes a fair amount of self-knowledge to understand another person's emotional difficulties. Psychoanalysts are required to undergo a training analysis, and an increasing percentage of non-analytic psychiatrists seek psychotherapy for themselves. The average physician, on the other hand, has little need or desire to look more closely into his own emotional make-up.

4. *Part of the problem in referring the patient to a psychiatrist is the expense involved. Some psychiatrists are rumored to charge $50 an hour for psychotherapy. Is this true?*

As the MEDICAL ECONOMICS surveys demonstrate, psychiatry is not one of the best-paid specialties. Generally, well-trained psychiatrists who do psychotherapy charge $15 to $20 an hour; they see only seven or eight patients a day.

The largest incomes in our specialty are often made by poorly trained psychiatrists. They do a good deal of shock therapy and preaching, for which they may charge exorbitant fees. Since such a man knows he'll be seeing the patient only a few times, he finds it possible to charge much higher rates.

5. *Psychiatrists seem to be cut-*

ting themselves off from medicine, and we don't know what to make of it. Most of you don't practice neurology any more, and you can't treat so much as a common cold.

I'd like to quote Dr. Gregory Zilboorg on this point: "Psychiatry was born out of medicine and matured by medicine . . . The psychiatrist, dealing more directly with the inner life of man than [any other] doctor . . . , has always had to draw upon certain special prejudices concerning the human mind, or upon various philosophies prevailing at a given time, in order to create for himself a medical-psychological frame of reference usually not found in autopsy material . . .

"The earliest attempts to form such a frame of reference go back to the 13th century . . . These references to human experience came not from the medical men of the time, but from the theologians and philosophers . . . It is clear, therefore, that psychology . . . was a product, if not an integral part, of philosophy. For many centuries . . . when a medical man espoused the cause of psychology, he would become a philosopher rather than a psychiatrist. John Locke is a case in point; as late as the 17th century, psychology was much closer to philosophy than to medicine."

So it's true that the psychiatrist functions on the outskirts of medical

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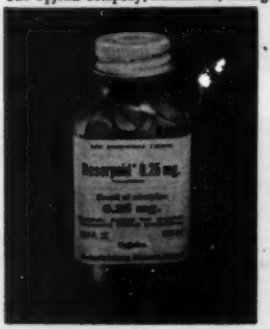


practice. Although drugs and shock therapies continue to occupy an important place, the study of *interpersonal relationships* dominates the specialty.

To the average physician, the most acceptable aspect of psychiatry is probably that portion most closely related to organic medical science. He thinks kindly of those psychiatrists who approach mankind's miseries with the aid of the microscope. Yet psychiatry is getting more and more away from the organic. Why?

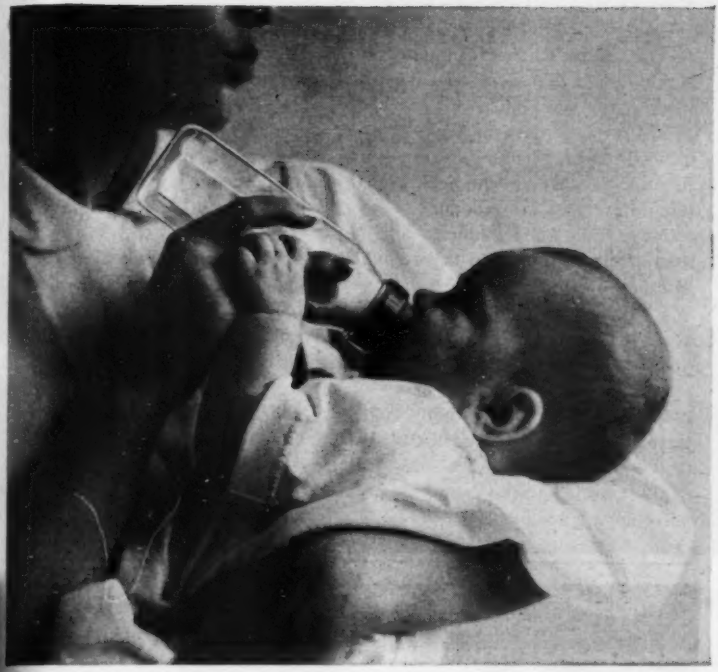
Obviously, because the manner in which men deal with each other has become increasingly important. Today, in fact, a psychiatrist may even refrain from giving a particular medication to his patient because of its possible meaning in terms of their interpersonal relationship.

Before other doctors scoff at such an attitude, they should remember their own use of placebos and other devices that inherently recognize the potency of interpersonal relationships.

6. *Why does the psychiatrist make such a mystery of what he does? Are the rest of us too stupid to understand, or is he just keeping his secrets in the fraternity?*

I think this is a fourfold problem:

¶ Most doctors stumble over the language barrier that separates them from any specialized field. There's



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need for more study of human psychodynamics than is ordinarily provided in medical school.

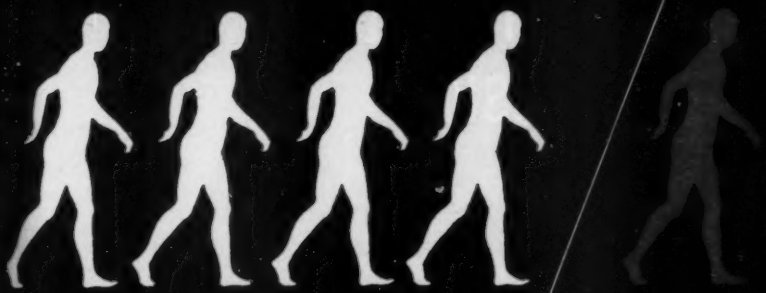
¶ Most psychiatrists have done too little to bridge the gap between themselves and their medical brethren. Many feel misunderstood and retire to their solitary offices, rather than attempt to explain themselves to their colleagues.

¶ Most people have difficulty in understanding what a psychiatrist does because of their own emotional resistance. The fact that psychiatrists know something about emotional distress may make them appear somewhat superior in the eyes of the physician who has difficulty with his own feelings.

¶ Most people are harassed and made anxious by the kind of world we live in. Psychiatry may be held in contempt because it hasn't provided an answer. It's only human to expect that "someone" will show us the light, impossible as that may seem to be.

Actually, most psychiatrists feel some humility before their medical colleagues. We can't claim any modern medical miracles comparable to those in other specialties. All we can claim at present is that we're on the right track.

Given patience and understanding, we hope eventually to make a contribution in keeping with the glory of modern medicine. END



you can prevent attacks of angina pectoris

Peritrate, a long-acting coronary vasodilator, has repeatedly demonstrated its effectiveness in preventing attacks of angina pectoris in 4 out of 5 cases.[1,2,3]

Prophylaxis with Peritrate results in fewer, less severe attacks, reduced nitroglycerin dependence, improved EKG's where abnormal patterns exist and increased exercise tolerance.

Peritrate's action is similar to that of nitroglycerin but considerably more prolonged . . . "favorable action [can] be elicited for 5 hours or more after its administration."[4]

Usual dosage is 10 to 20 mg. *before meals* and at bedtime.

The specific needs of most patients and regimens are met with Peritrate's four dosage forms. Peritrate is available in both 10 and 20 mg. tablets; Peritrate Delayed Action (10 mg.) allows uninterrupted continuation of protection through the night. Peritrate with Phenobarbital (10 mg., with phenobarbital 15 mg.) where sedation also is required.

1. Winsor, T., Humphreys, P.: Angiology *3*:1 (Feb.) 1952. 2. Plotz, M.: N. Y. State J. Med. *52*:2012 (Aug. 15) 1952. 3. Dailheu-Geoffroy, P.: L'Ouest-Médical, vol. 3 (July) 1950. 4. Russek, H. I., *et al.*: Am. J. M. Sc. *229*:46 (Jan.) 1955.

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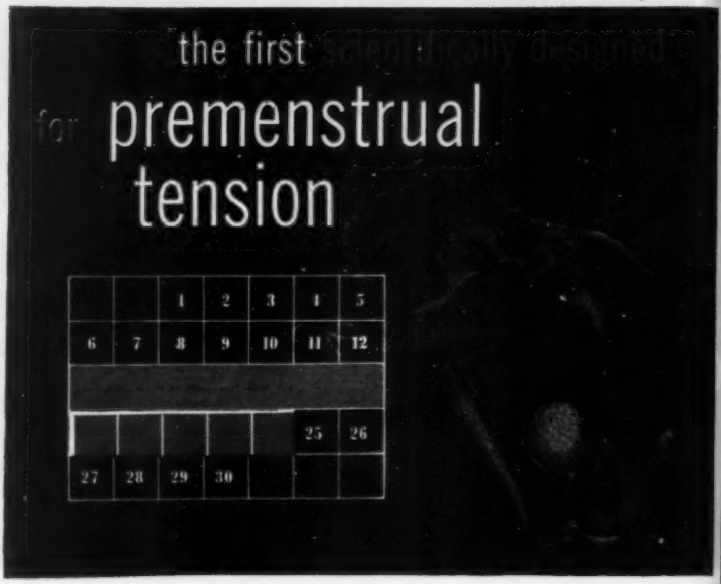

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Brand of Bromaleate, Brayten

NEO BROMTH, the first preparation developed specifically for treatment of premenstrual tension, continues to be found the most satisfactory therapeutic agent in this condition.

Bickers found that "abnormal water storage can be blocked or eliminated and clinical relief of symptoms obtained in most patients . . . "[1] with NEO BROMTH.

Greenblatt recently stated: "Clinically, we share Bickers' enthusiasm for this drug in the management of premenstrual tension, especially where there is associated edema."[2]

NEO BROMTH is non-toxic, *non-hormonal* therapy and contains no ammonium chloride. Each 80 mg. tablet contains 50 mg. of pamabrom (2-amino-2-methyl-1-propanol 8 bromo-theophyllinate) and 30 mg. of pyrilamine maleate.

Dosage: 2 tablets twice daily (morning & night) beginning at onset of symptoms —usually 5 to 7 days before menses. Discontinue at onset of flow. Supplied in bottles of 100 tablets on prescription only.

1. Bickers, W.: Southern M.J., 46:873, Sept., 1953
2. Greenblatt, R.: GP, 11:66, March, 1955

BRAYTEN PHARMACEUTICAL COMPANY Chattanooga 9, Tennessee

Optometry Wants to Halt M.D.-Refracting

By clever publicity, and by pressure on the country's lawmakers, it intends to curb your rights. And other nonmedical 'specialties' may soon follow its lead, warns this physician

By Robert W. Johnson, M.D.

● For years, nonmedical "specialists" have been infiltrating areas of medical care traditionally reserved to the licensed M.D. And, once in, such "specialists" are seldom satisfied. Their next move is to try to stake out an *exclusive* claim to their "specialty."

Psychologists administer psychotherapy; chiropodists treat club feet. And the average physician is likely to stand by and say, "Well, it's not *my* fight."

That's where he's wrong. Each new invasion of any medical field may well pose a threat to medicine in general.

As an example of what can happen, let's consider the problem currently facing ophthalmologists across the country:

Today, optometrists do most of the refractions in this country. A patient *can* go to an ophthalmologist for refraction, of course. But if the optometrists get their way, it may soon be illegal for the ophthalmologist to refract eyes.

Should that happen, an effort may be made to tell phy-

doubles the power to resist food in obesity

Obocell has this double action:

1. Controls your patients' appetites at meals.
2. Appeases their gnawing bulk hunger.

More than that, the effect of Obocell "carries over" between meals so that your patients are not tempted to break their diets.

And Obocell saves money for your patients.

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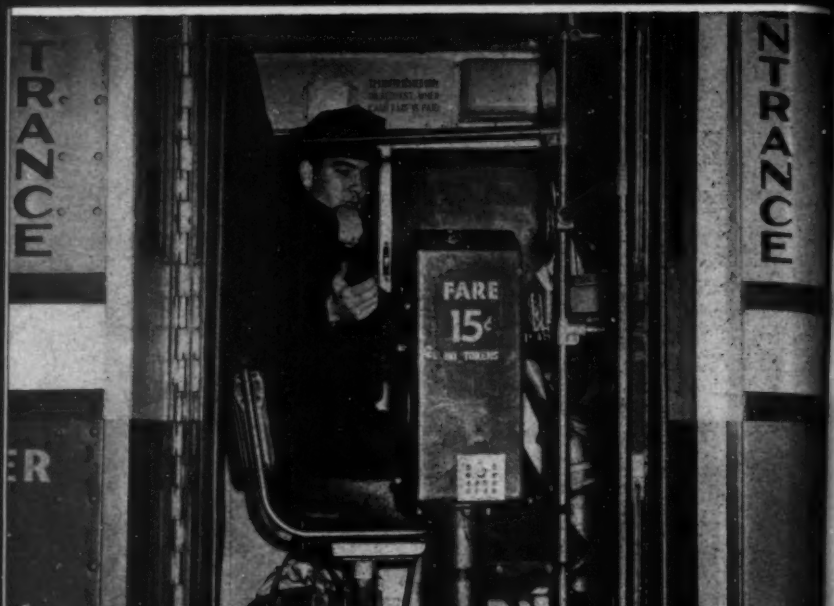

Laxative action ... *suited to his routine*

Relief of temporary constipation: Agoral is suited to the acutely constipated patient who can neither take time off for a "purge," nor time-out to answer the sudden urge induced by strong laxatives: the head of a one-man business; the executive committed to a day of important conferences; the bus driver on a long haul; people in the theatre, the pulpit, the factory, the home. For all who need relief of temporary acute constipation, pleasant tasting Agoral provides positive results without urgency.

No urgency; evacuation which adjusts to schedule: A dose taken at bedtime almost invariably produces results the following day. Elimination is comfortably achieved by mild, positive peristaltic action, not by violent paroxysms of unrestrained hyperperistaltis.

No griping; interim discomfort avoided: Agoral's action is sustained uniformly during its passage through the intestinal tract; and it causes no uncomfortable griping, embarrassing flatulence, distention or stomach distress.

Dosage: On retiring, ½ to 1 tablespoonful taken in milk, water, juice or miscible food. Repeat if needed the following morning two hours after eating. Contraindications: symptoms of appendicitis; idiosyncrasy to phenolphthalein.

Supplied: bottles of 6, 10 and 16 fluid-ounces; and as Agoral Plain (without phenolphthalein), bottles of 6 and 16 fluid-ounces.

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mineral oil emulsion with phenolphthalein

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sicians that they have no right to operate biochemical laboratories. Or that they may no longer cut corns, administer psychological therapy, prepare fluid extracts—or even give massage.

Organized optometry is waging a double-pronged offensive against the physician's right to do refractions:

1. It's publicizing the optometrist as a better eye examiner than the M.D.; and

2. It's seeking legislative sanctions that would permit no one but the optometrist to refract eyes.

In "educating" the public to accept only "qualified" eye examiners, the optometric societies are claiming loudly that the optometrist studies more about refractions than does any medical student. Publicity campaigns sponsored by the American Optometric Association speak of the optometrist as "a specialist in the care of vision." Such statements often effectively blur the distinction between optometrist and ophthalmologist.

Or take an advertisement that the optometrists are now spreading across the nation's newspapers. Its key sentence: "Fifteen thousand optometrists serve 80 per cent of vision patients; 20 per cent go to 6,000 ophthalmologists." The lay reader is bound to get the impression that ophthalmologists are therefore qualified to treat only a small percentage of eye patients.

When it comes to educating its own recruits, optometry goes even further. Here are a few pertinent passages from H. W. Hofstetter's "Optometry," a standard textbook in the field:

¶ "The medical refractionist receives relatively few cases of referral from other medical practitioners. He depends mostly upon propagandizing the public. The general practitioner is unwilling to refer patients to the medical eye specialist, lest the specialist . . . steal his patients."

¶ "Why the ophthalmologist elects to spend a good share of his time refracting is not easy to answer. The customary answer given is that the time consumed by ocular pathology is so little that other work must be done to provide full-time employment."

¶ "Most of the factors suggest that the ophthalmologist will engage less and less in refractive work as time goes on."

'M.D. Should Retire'

Even more illuminating is this paragraph from an editorial (frankly entitled "An Offensive for Optometry") in the Southern Optometrist:

"Ophthalmologists became interested in refraction and have since used every means to usurp the field . . . The time has come for optometry to step into an offensive position and remain so until the field of non-pathological eye care is relinquished by medicine and assumed in its full scope by optometry. Refracting is

not any part of medicine. It occupies no important position in medical education . . . The medical man should retire from the field of refraction."

Such statements obviously go far beyond optometry's efforts to protect *its* prerogatives. They constitute an offensive tactic, aimed at stripping away the *M.D.'s* prerogatives.

The second—and probably more dangerous—method of attack is legislative action. Already within legal gunsight in a few areas are two of the physician's loyal supporters: the ophthalmologist's office technician and the dispensing optician.

In some state legislatures, bills have been introduced to bar non-M.D. office assistants from doing refractions even under direct supervision. And in New Mexico's Bernalillo County last year, optometrists pressed for legal action by the District Attorney against opticians who duplicated eyeglasses or mountings.

In response to this pressure, the District Attorney wrote to local opticians: "You have duplicated mountings without a prescription . . . If you do not cease . . . you leave this office no alternative but to prosecute you."

The New Mexico Ophthalmological Society condemned the incident as working unnecessary hardship on the patient by forcing him to pay for unneeded and unwanted refrac-

tions. And the society openly accused "a group of optometrists" of having brought the complaint against opticians.

But by far the most threatening offensive yet has been launched by the Congress of the American Optometric Association, which last year in Seattle adopted the following resolutions:

¶ "Resolved, that it is the stated policy of the American Optometric Association that the field of visual care is the field of optometry, and should be exclusively the field of optometry."

¶ "Resolved, that individual state [optometric] associations make serious study of the optometry laws to the end that exemptions be restricted, limited, and ultimately eliminated; and that encroachments by untrained, unqualified, and unlicensed persons into the exclusive field of optometry be prevented through the established enforcement agencies in the respective states."

Who do you think these "untrained, unqualified, and unlicensed persons" are? Salesgirls in the five-and-ten? No, Doctor. They're you and I.

Who says so? The optometrists themselves do. Here's how the Optical Journal and Review of Optometry for August, 1954, clarifies the Seattle declaration:

"Where the resolution points out that throughout the years the optometry laws have granted exemptions to certain groups and classes,

it must be kept in mind that the exemption of physicians is the most common . . ."

But most people—certainly most legislators—won't read this clarifying statement. They may simply assume that the "untrained, unqualified, and unlicensed persons" are quacks and cultists. And so, in the belief that he's striking a blow for better health measures, many a lawmaker may cheerfully vote to eliminate *all* exemptions from optometry laws.

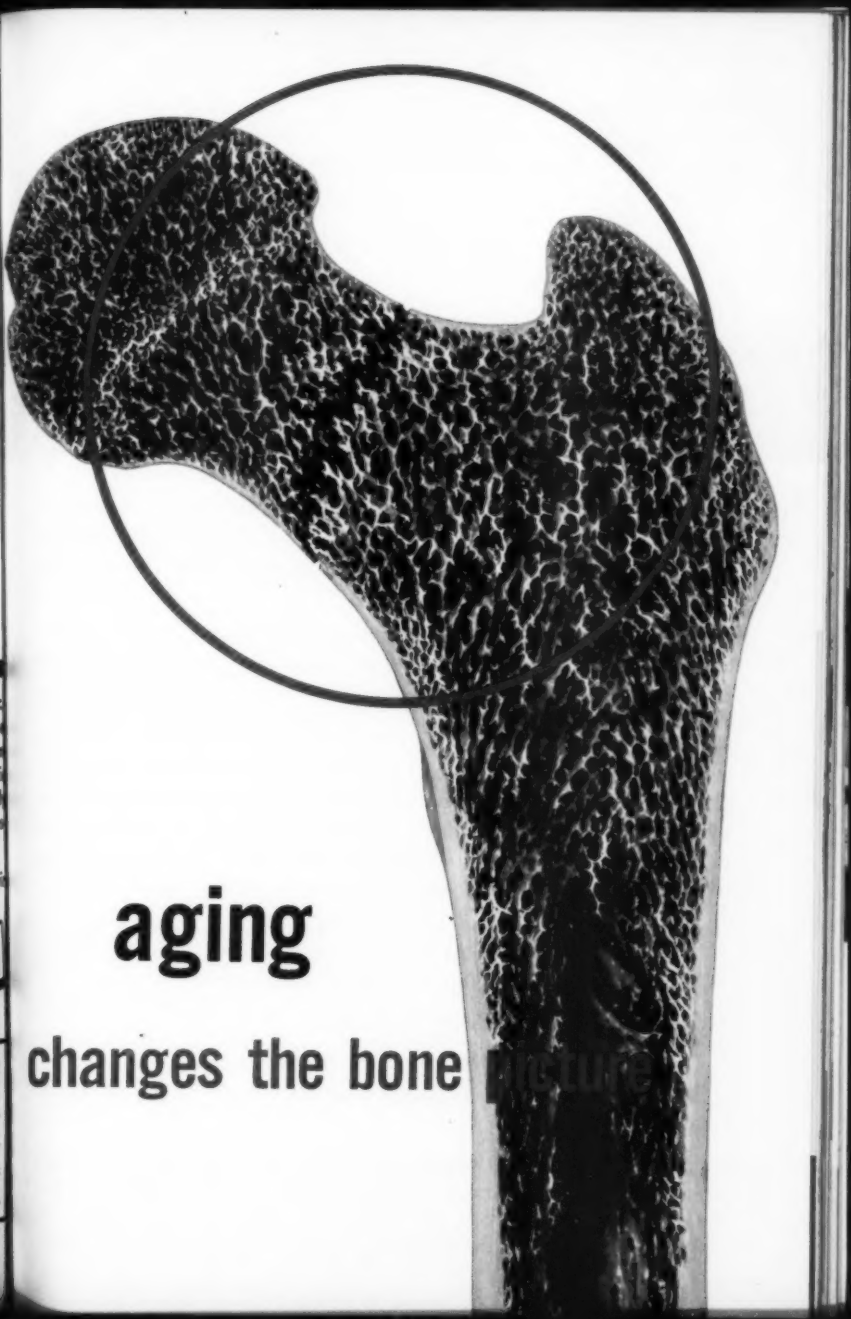
Possible result: criminal prosecution for the physician who refracts.

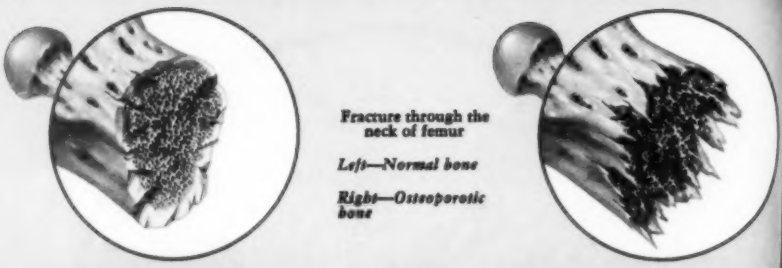
Naturally, the law won't *say* it's a crime for physicans to refract. It'll simply say—if the optometrists get their wish—that only optometrists may refract eyes. Such a clause could easily be slipped into a bill outlawing the sale of sunglasses in butcher shops, or into a bill prescribing visual standards for truck drivers.

"Well," you might reply, "that would be too bad for the ophthalmologists. But I'm a G.P."

I repeat: It would be bad for you, too.

Optometry's current tactics mark the first time since Prohibition that an organized effort has been made to curtail the rights of the licensed physician. If any such offensive succeeds, you can be sure of others from other directions. END


aging
changes the bone picture



Fracture through the neck of femur

Left—Normal bone

Right—Osteoporotic bone

Osteoporosis causes bone to become fragile, less elastic, and more susceptible to fractures

Fractures, particularly of the neck of the femur, are common in elderly patients of both sexes but they occur more frequently in older women.[1] These fractures usually result from a minor shock or fall rather than serious trauma.[2]

The aging process, with its accompanying decline in sex hormone function, is the most frequent cause of osteoporosis. The greater incidence of osteoporosis in women has been related to the fact that "gonadal function in old persons is more markedly reduced in females than in males."[3]

■ CLINICAL SIGNS MAY APPEAR LONG BEFORE X-RAY DETECTION

Osteoporosis frequently escapes early recognition because accurate detection by x-ray of changes in bone density is virtually impossible until at least 30 per cent of the calcium has been lost.[4] Clinical signs and symptoms therefore have considerable diagnostic significance.

■ SIGNS AND SYMPTOMS

- "Low back pain" or dull, tired, aching feeling along the spine
- Nervousness, weakness, easy fatigability
- "Rounding" of the shoulders
- Increased susceptibility to fracture, particularly of the hip, in elderly women

Osteoporosis is almost "physiologic" after the menopause and if all women in this age group are studied carefully, x-ray evidence of decreased bone mass will be obtained in over 50 per cent and previously unrecognized vertebral fractures will be found in about 30 per cent.[5]

■ Why "Premarin" with Methyltestosterone Therapy Is Recommended

"Premarin" with Methyltestosterone therapy utilizes the complementary effects of combined estrogen and androgen on bone and protein metabolism. Estrogen stimulates osteoblastic activity and increases calcium and phosphorus retention, while androgen exerts an anabolic or protein-forming action. Furthermore, the opposing action of the two steroids on sex-linked tissues minimizes the possibility of undesired side effects.

■ Osteoporosis Responds to Combined Estrogen-Androgen Therapy

Older women with hip fractures respond especially well. Healing is accelerated and, according to Reifenstein, the patients "get back on their feet more rapidly with the hormone therapy than without it."[3] As a group, patients receiving combined estrogen-androgen therapy can expect "considerable relief from pain . . . a gain in weight, an apparent increase in thickness of the skin and a generally improved sense of well-being."[4] The prognosis for bone recalcification is good, provided therapy is continued for extended periods.

■ Suggested Dosages

"Premarin" with Methyltestosterone may be administered in the following dosage schedules: 2 or 3 tablets No. 879 (yellow) daily, or 4 to 6 tablets No. 878 (red) daily.

In the female, it is suggested that combined therapy be given in 21 day courses with a rest period of about one week between courses, and be continued for 6 to 12 months; following this period, the patient may be maintained with cyclic therapy employing "Premarin" Tablets alone.

In the male, a careful check should be made on the status of the prostate gland when therapy is given for protracted intervals.

1. Starr, P.: Geriatrics *10*:174 (Apr.) 1955.
2. Callahan, J. J., and Segraves, J. E.: J. Am. Geriatrics Soc. *2*:613 (Sept.) 1954.
3. Reifenstein, E. C., Jr., in Harrison, T. R.: Principles of Internal Medicine, ed. 2, New York, The Blakiston Company, 1954, pp. 697, 699.
4. Hart, G. M.: Geriatrics *5*:321 (Nov.-Dec.) 1950.
5. Fiskio, P. W.: GP *11*:70 (May) 1955.

For the relief of

Postpartum Breast Engorgement

(when lactation is to be suppressed)

"Premarin" with Methyltestosterone has been successfully employed to relieve the discomfort of postpartum breast engorgement with virtually none of the unwanted side effects likely to occur with estrogen or androgen alone.[3]

Other Indications

- Osteoporosis
- Dysmenorrhea
- Climacteric (female and male)—in certain cases
- Malnutrition (in the female)
- As an adjunct to treatment with cortisone in rheumatoid arthritis

SUPPLIED IN TWO POTENCIES: the *yellow* tablet (No. 879) contains 1.25 mg. of conjugated estrogens (equine) and 10 mg. of methyltestosterone; the *red* tablet (No. 878) contains 0.625 mg. and 5 mg. respectively. Both potencies are available in bottles of 100 and 1,000 tablets.

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100 Million Subscribers —What Next?

The hospitalization plans have gone over the top, with the surgical plans not far behind. Here's what this means to medical men

By R. Cragin Lewis

● Three years ago, Dr. Louis H. Bauer, then president of the A.M.A., was asked about the medical profession's hopes for voluntary health insurance.

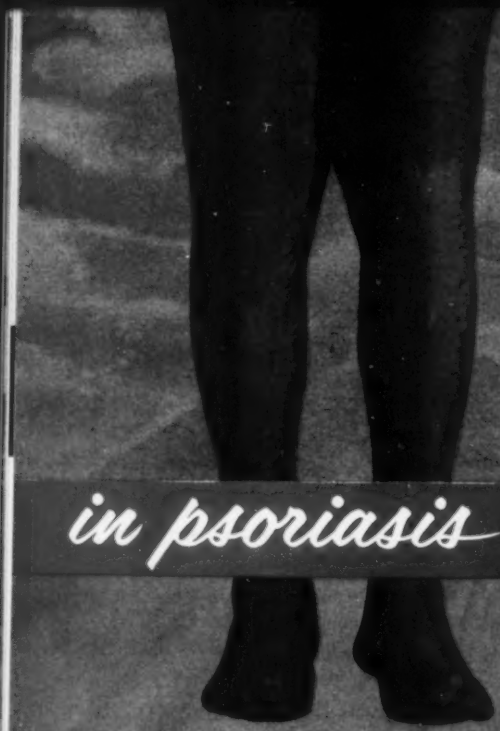
"Our aim is coverage of 100 million people," he replied. "When we reach this goal . . . and remedy the deficiencies . . . voluntary insurance will be a success."

Dr. Bauer's target has now been straddled. The hospitalization plans have shot past it, with 104 million people enrolled. The surgical plans are still short, with 89 million covered; but they're closing in on the target fast. By the summer of 1957—at present enrollment rates —more than 100 million Americans will carry insurance against *both* surgical and hospital bills.

When we reach that goal, what next?

Dr. Bauer's second stipulation ("... remedy the deficiencies . . .") will then become the profession's major concern. Until now, mass enrollment has been the main thing. But hereafter you'll be hearing more about such health-plan problems as these:

1. The protection that hasn't been provided. "There is a general opinion that it is desirable to cover all or nearly all . . . hospital services," the Health Information



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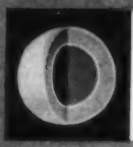
Entozyme provides pancreatic enzymes to help restore normal metabolism, so commonly disordered in the psoriatic . . . and thus represents an effective systemic approach to successful therapy.

*Ingels, A. H.: California Medicine 79:427, 1953.



Each Entozyme 'tablet-within-a-tablet' contains:

—*in its gastric-soluble outer coating* .	Pepsin, N.F.	250 mg.
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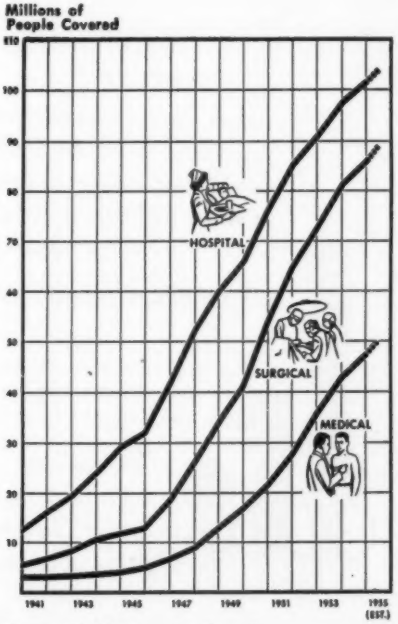
Foundation reported last year. But the typical hospitalization-plan subscriber who goes to the hospital still has to pay 11 per cent of the cost himself. And one out of five subscribers pays at least 40 per cent.

So too with the surgical-plan subscriber—only more so. Typically, he has to pay 25 per cent of his surgical bill out of his own pocket. And one out of three subscribers has to pay at least 40 per cent.

"By and large, the payments made by insurance for surgical costs fall far short of equaling the total charges," said the Health Information Foundation in reporting these facts. "The difference would seem to involve more than a normal deductible or co-insurance feature."

2. *The coverage that hasn't been bought.* Doctors seem increasingly aware that medical procedures can be just as difficult—and therefore just as expensive—as surgical procedures. Some insurance carriers seem aware of it, too. But the medical coverage they offer still hasn't

How the Health Plans Have Grown



Source: Health Insurance Council

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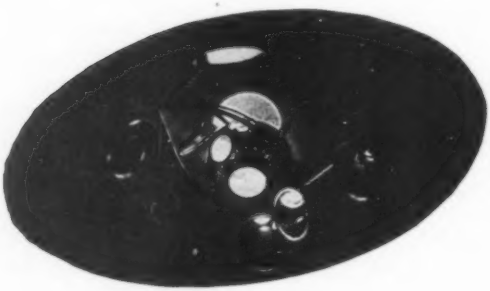

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★T.M. Reg. U.S. Pat. Off. for S.K.F.'s brand of chlorpromazine.

caught on with most of the public.

"Major medical" is another kind of protection that not many people have taken to yet. This insurance covers a major part of the costs of unusually serious and expensive illnesses. Many doctors regard it as the most important type of all.

True, "major medical" is relatively new. And granted, it's growing relatively fast. But the fact remains that fewer than 2.5 million people have bought such policies so far.

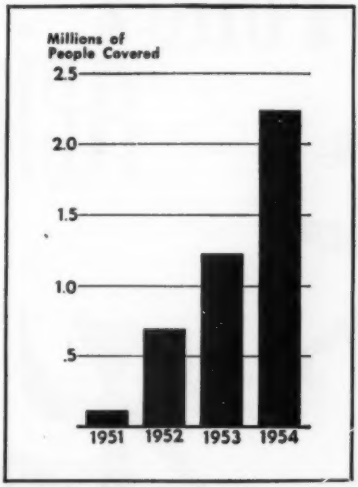
3. *The people who haven't been reached.* "Certain categories of people are difficult to insure," a Senate report pointed out some time ago. That this problem hasn't yet been solved is indicated by a recent cross-sectional sampling:

Taking all categories together, about 60 per cent of the people have some form of health insurance. But only 30 per cent of retired people have been reached; only 31 per cent of seasonal workers; only 35 per cent of farm families; and only 41 per cent of families with incomes under $3,000.

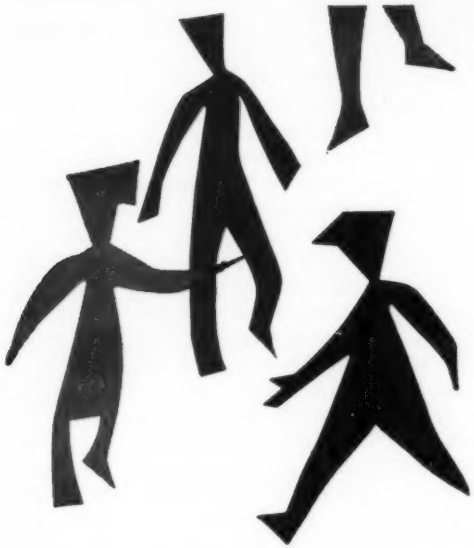
These are some of the problems that will have to be solved before voluntary health insurance can be called a complete success.

Its quantitative triumphs are already a matter of record—as witness the charts reproduced with this article. But its qualitative triumphs are still in the making. And doctors may have more to do with their making than anyone else. END

The Boom In 'Major Medical'



Source: Health Insurance Council



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Commission Calls for Less Federal Medicine

'Leave to private initiative all the functions that citizens can perform privately,' urges the Commission on Intergovernmental Relations in its report to the President and to Congress

By D. A. Drennen

● The Federal Government should intervene in the lives of its citizens only in situations that might get out of hand or be too big to handle at the state or local level. Moreover, even state and local governments should follow a hands-off policy when their citizens are able to act for themselves.

So says the recently released report of a two-year study of intergovernmental relations.

The study was made by a commission that President Eisenhower proposed and that Congress created in 1953. Commission Chairman Meyer Kestnbaum (president of Hart, Schaffner & Marx) and Vice Chairman Alfred E. Driscoll (former Governor of New Jersey) have delivered the report of their 25-man group to Mr. Eisenhower for transmission to Congress. Presumably Congress will consider it at its next session.

Inherent in the report of the commission is what amounts to a philosophy of the federal system in operation in the United States. It is of general significance to all who have a stake in the American concept of govern-

ment and of particular interest to physicians and others who have fought to protect that concept from the destructive effects of socialism.

The work of the Commission on Intergovernmental Relations has been compared with—but is readily distinguishable from—that of the Hoover Commission. The latter concerned itself largely with the executive branch of the Federal Government while the former has centered its attention on relationships among national, state, and local governments.

While of the opinion that the Federal Government wields far too much authority for the good of the people, the commission puts much of the blame for this on state and local governments. They have failed both to meet their responsibilities and to keep up with changing conditions, it says.

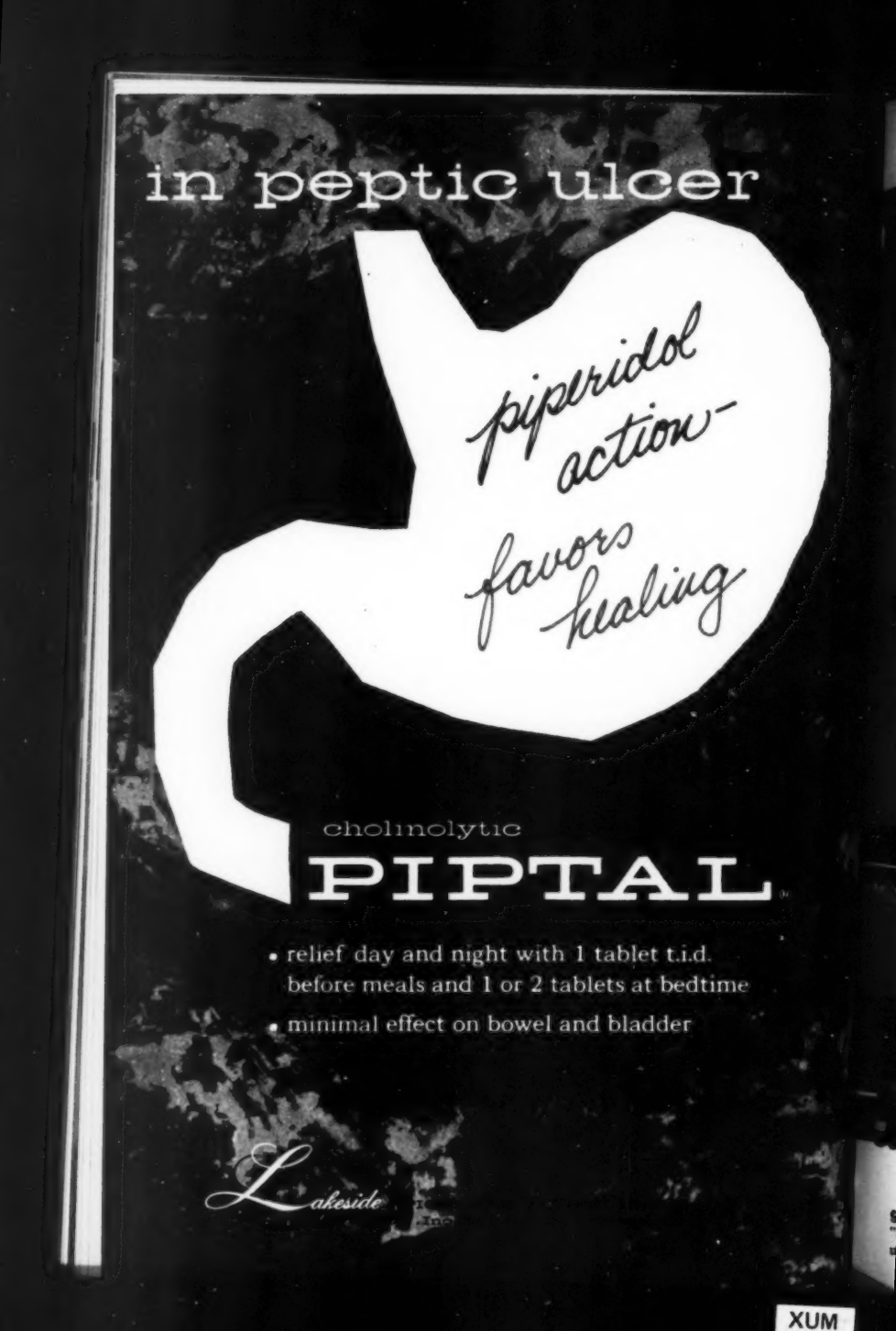
What It Recommends

The 90,000-word report of the commission includes these recommendations:

¶ "Use the level of government closest to the community for all public functions it can handle [including health functions];

¶ "Reserve national action for residual participation where state and local governments are not fully adequate and for the continuing responsibilities that only the National Government can undertake."

The commission's study of national-state-local government rela-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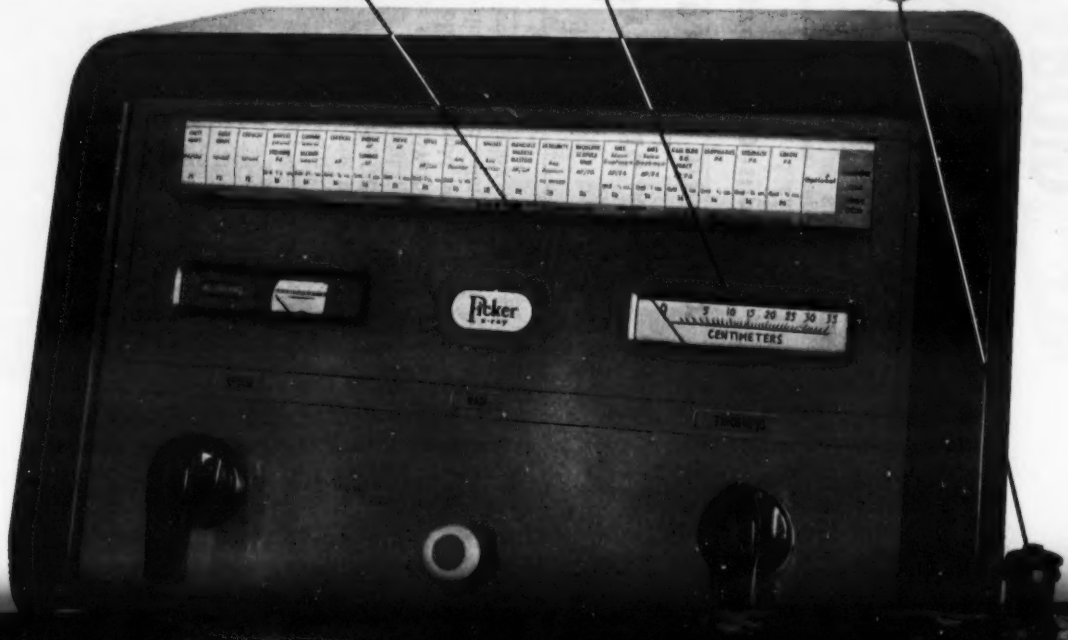

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tionships is the first to be made since the Constitutional Convention of 1787. Its report states that "where the problem of our federal system once appeared to be one of creating sufficient strength and authority in the National Government, today contrary concerns have aroused anxiety.

"The National Government now has within its reach authority well beyond what it requires for ordinary use. Forbearance in the exercise of this authority is essential if the federal balance is to be maintained."

In short, says the report, Washington's prime objective should be to "keep centralization to a minimum and state-local responsibility to a maximum." This statement applies, of course, to Government action in all fields, medicine among them; so it will be applauded roundly by private physicians.

But is limitation of national responsibility enough by itself? Far from it, says the commission: "A realistic program of decentralization" requires that the states and their subdivisions assume *their* share of the job of government, too.

Dividing the Work

Americans today, the report says, are torn between too much government and not enough government. One faction in their midst views Washington's expanding activities

as a grave threat to the traditional concept of states' rights and state responsibility. Another faction cheers for more centralized authority and increased services, even though these necessarily mean higher Federal taxes.

Both these factions go too far, the commission believes. It repeats that what we really need in this country is a nice balance between the two—a balance between central strength and local freedom.

There's a Paradox

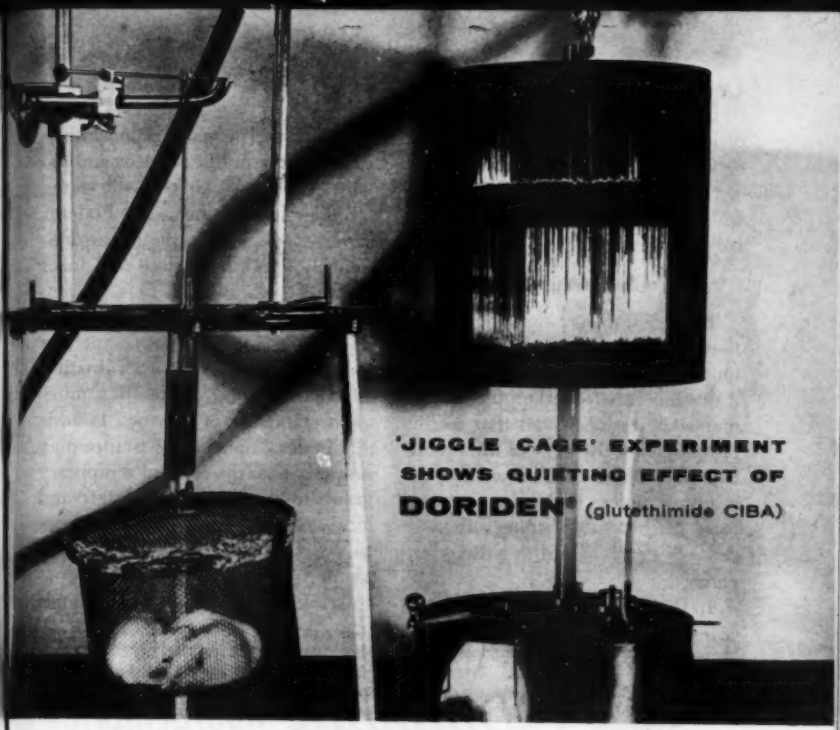
One of the biggest obstacles to decentralization of our Government, says the report, is the paradox of "too many local governments, not enough local government." Theoretically, the country's 109,000 local governmental units should be more than sufficient to solve the problem; but numbers alone won't do it, the commission emphasizes.

All too often, it says, a single area will be served by a municipality, a school district, a county, and one or more special districts. Some metropolitan areas embrace no less than 100 separate local government units. So what we need, it insists, is not *more* units but *stronger* units.

Local government will be strengthened, says the commission, if the states take these precautions:

¶ Assign to local governments those activities that they can properly handle, then give them the money to administer them.

¶ Let them choose their own form



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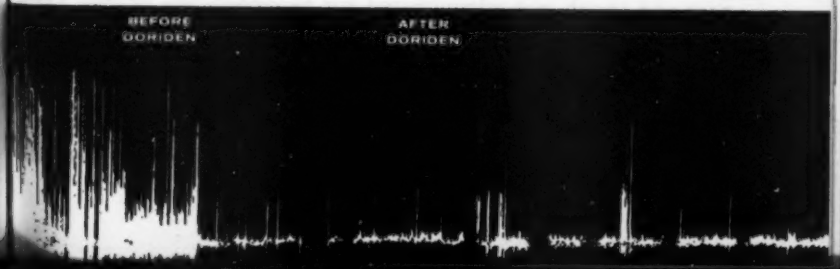


of local government and supply the services they feel they need.

¶ Let them grow and flourish by wide citizen participation and "home rule."

Cheaper, Too

The commission does not claim that overlapping of governmental units can be eliminated entirely. But it does feel that overlapping can be materially reduced and that in this reduction lies the hope of the American people for real tax relief. Already, it notes, Federal, state, and local taxes are siphoning off more than 27 per cent of the national income.

In the field of health, the commission believes, the main responsibility for providing public services and facilities should remain with the states and their subdivisions. The Federal Government, it says, should supplement, not supplant, state and local effort.

Proper contributions of the Federal Government, it feels, include conducting research, disseminating information, and promoting minimum standards of service. It adds that Federal financial assistance may properly take the form of temporary grants-in-aid to encourage state and local action, especially with respect to urgent health problems (for example, grants for tuberculosis control). It may also include assistance

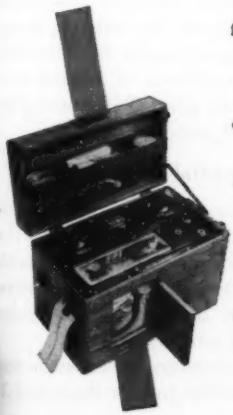
IN SICKNESS AND IN HEALTH

An electrocardiograph, such as a Viso-Cardiette, plays a *double* diagnostic role in the investigation of cardiac conditions.

When heart disease is present, the contribution of a 'cardiogram to the clinical picture is of indisputable value.

But, often overlooked is its importance in the patient *without* heart disease. Becoming more and more a part of the general examination, or check up, the electrocardiogram places in the physician's files information concerning the healthy patient that can well be of future value. Not only does it provide a norm or control with which to watch or study any progressive pathological changes, should they occur, but, when heart disease strikes, it is on hand to compare with the new record for information which would not have been otherwise available.

When you make your investment in better cardiac diagnosis by purchasing an electrocardiograph, be sure to consider the extra dividends that a Sanborn Viso-Cardiette will pay in accuracy, simplicity, and dependably continuous service.



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of a continuing nature to maintain health services at levels deemed necessary in the national interest.

The commission notes with satisfaction that "state spending for public health is increasing in relation to grants-in-aid. In 1943, the states and localities were spending $1.90 for each dollar received in Federal grants. By 1953, they were spending $3.92 for every dollar received."

The report stresses that continuance of any health grant should be based upon careful study of needs and objectives. Otherwise, it warns, a grant may become, in effect, a permanent subsidy.

Grants for special health purposes, it says, should not be continued indefinitely, but should be tapered off as their objectives are achieved. At the same time, grants for general health purposes "should be aimed at the support of a national pattern of minimal standards of health. These standards should be developed jointly by national, state, and local governments with the advice and assistance of nongovernmental health groups" (for example, the medical profession).

Hospital Building

The commission also recommends continuation of grants and loans for building hospitals and other health facilities. But it adds that relative state needs should be kept under continuing scrutiny.

The commission says continuing study should be given to the suitabil-

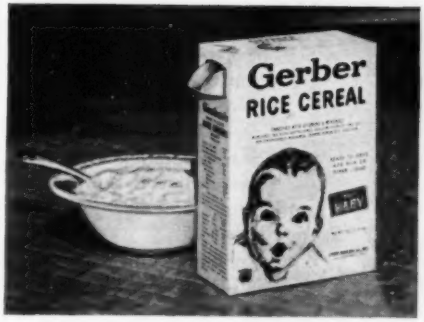
ity of the formulas now being used to determine hospital-bed requirements. It wants to make sure that the latest treatment methods are taken into account in establishing future needs.

"A question has been raised," it says, "as to the extent of utilization of hospital beds financed by the National Government. It has been reported that there has been an increase in unused beds during the past few years in military and Veterans Administration general hospitals. In any areas where Veterans Administration or military hospitals are closed for lack of use, the commission believes it should first be ascertained whether these hospitals can be made available to public or private agencies before Federal grants are allocated for new construction."

The report points out that "the need for hospital construction can often be reduced through the use of appropriate but less expensive facilities, such as nursing homes and clinics. It should be possible for the states to broaden their treatment of mental illness by using specialized non-hospital facilities and by placing mental patients in hospital beds made available by the decline of other health problems."

Medical Research

The Government should, as far as possible, decentralize medical research, turning it over to institutions or states that are equipped to



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rich source of natural vitamin-B complex

Digestible! Thorough precooking and low crude fiber (averages 0.8%) assure easy digestibility. Bland flavor and smooth texture make Gerber Rice Cereal especially palatable to the young infant.

easy digestibility

Important P. S. Gerber Cereal Quads — a 4 in 1 assortment of Rice, Barley, Oatmeal and Cereal Food (a mixed cereal) — makes it easy and economical for the mother to introduce cereal variety. Once the baby is established on Rice, the other cereals may be introduced, one at a time. If cereal allergy shows up, diagnosis is relatively simple.

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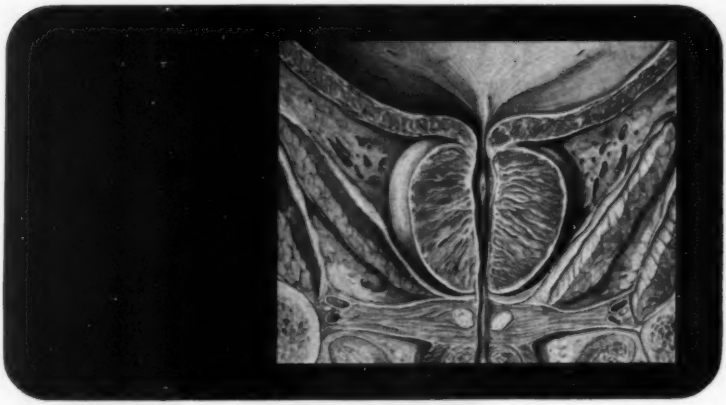
do such research, recommends the commission. It adds that "although the contributions of Federal agencies to medical and health research have by no means been negligible, research advances in these fields have come mainly from university laboratories and other public and private agencies . . . Through the grants-in-aid device, the National Government can keep both public and private research groups vigorously interested."

Coordination Needed

The Government, it goes on to say, "should seek to ascertain the nature and extent of medical research being conducted over the country by private as well as public agencies. Some reasonable effort to coordinate these activities is warranted, not only to prevent work being continued where research objectives have already been achieved, but to foster communication among those working in related fields."

But the real message of the report should not be lost in the maze of its details.

The commission holds to the basic view that government must be a two-way street between the governed and the governing. Only when government becomes everybody's business, it concludes, can the federal system truly be acclaimed a success. END



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137 cases of prostatitis were treated with Furadantin with the following results:

	Acute prostatitis	Chronic prostatitis	Total
No. cases	20	117	137
Cured	15	30	45
Improved	4	56	60
Failed	1	31	32

(Personal communications to the Medical Department, Eaton Laboratories.)

Furadantin has a wide antibacterial range

Furadantin is effective against the majority of gram-positive and gram-negative urinary tract invaders, including bacteria notorious for their resistance. Furadantin is not related to the sulfonamides, penicillin or the 'mycins.

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THE NITROFURANS—A UNIQUE CLASS OF ANTIMICROBIALS O_2N PRODUCTS OF EATON RESEARCH

Polio Post-Mortem: What Really Happened

[CONTINUED FROM 153]

tion of the Public Health Service Laboratory of Biologics Control to take consistent performance on the part of the manufacturers somewhat for granted.*

Was It Inevitable?

What can U.S. doctors learn from all this?

It's apparent, to begin with, that voluntary health agencies have become so potent that they can, if they wish, successfully short-cut organized medicine. And there doesn't seem to be much that doctors can do about it except writhe and pass resolutions.

Such voluntary organizations include perfectly respectable physicians in their committees and medical departments. For example, Dr. Thomas P. Murdock, an A.M.A. trustee, is a member of the N.F.I.P. general advisory and vaccine advisory committees. None the less, the agencies feel primarily responsible to the public, whence comes their support.

They have tremendous power to raise funds and expedite medical research. Yet their strength is also their weakness. They rely on anxiety-arousing techniques, on sentiment and enthusiasm, to keep the public excited and the dollars rolling in. Result: a certain breathless urgency quite alien to the calm of the conscientious physician, who must face the sick patient and try, in a one-to-one relationship, to help him.

The voluntary health agency is a peculiarly American phenomenon, a product of free enterprise and the old vigilante spirit. Some uncharitable fellow has called the people who live by such means "health hucksters."

One of the products they have to sell is "result research." They raise money to finance research to get results. And they have to show their results in order to get more money. Inevitably, pressure builds up on the scientist.

A Reason to Rush

The Polio Foundation happens to have been more successful than most; it is already tantalizingly close to becoming the first agency to conquer a disease by popular subscription. Mr. O'Connor and his confreres had very human reasons, then, for being in a hurry.

Yet you cannot satisfy the needs of the showman and the scientist out of the same box. Dr. Salk may look like an all-time money winner for the N.F.I.P.; but he isn't Citation, and the scientific mind is no race track. Surgeon General Leonard A. Scheele commented aptly on this speed-up aspect in his "White Paper" to Mrs. Oveta Culp Hobby:

"Events which in the traditional

*See editorial, page 86, this issue.

course of scientific development would have covered years were telescoped into months and, as a result, both successes and failures have been magnified."

You're in the Middle

Still, Dr. Scheele maintained, the world stood to gain from this country's efforts to speed availability of an effective polio vaccine.

Perhaps so. But some doctors will disagree. Despite all the acceleration, 9 million children did *not* begin the 1955 polio season with their vaccine shots complete. There were 5.5 million with only one shot, for the most part, and another 50 million who faced the summer as always before—without protection.

Then there's that incalculable loss of faith that comes when a patient concludes that his physician doesn't quite know what he's doing. This, I suspect, is why so many doctors resent Basil O'Connor.

In the business world, Mr. O'Connor would be deserving of nothing but admiration for his courage in taking the risk, plunging ahead, and marketing his product. That's just plain American business genius.

But in medicine, things must be different. For one thing, the customer isn't always right. It's often the doctor's job to guide him and save him from going astray.

What the N.F.I.P. did wrong was this: It surrendered to the anxiety of parents looking over its shoulder; and it drove its immunization pro-

PEDIATRICS BULLETIN

Prepared In The Interests Of The Profession By The Pediatrics Consultant Staff Of H. J. Heinz Company

LABELLING OF MEDICINES FOR HOME USE

IT HAS LONG been traditional that prescriptions should be labelled only with directions for their administration without identification of the contents. A recent editorial* questions whether this old custom is correct. Pediatricians especially should consider the value of the routine labelling of medications for children with the scientific name and concentration of the essential drugs.

The risk, by labelling, of increasing unwise medication of children by their parents must be considered. However, the delay in treating cases of accidental ingestion by children of unidentifiable medicines, and the advantage to a newly consulted doctor in knowing immediately what medication the child has previously taken, is important. The editorial further suggests, "Provisions can be made to safeguard the prerogative of the prescribing physician . . . The printed statement, 'Do not label contents' may be included on all prescription blanks. If the physician does not want his prescription identified, he merely checks the box alongside the statement." Obviously, a check that requests labelling could also be practical.

Certainly, in most cases there are advantages in the parents clearly understanding what they are giving their children.

NOTE: These bulletins are designed to help disseminate modern pediatrics knowledge to the general medical profession and appear periodically in Medical Economics.

*Bulletin of the American Society of Hospital Pharmacists Vol. 11, No. 6, Nov. 1954, p. 477

gram beyond the tolerance limits of the diverse system through which the vaccine had to pass to reach the children of those parents. This system involved all kinds of people: scientists, pharmaceutical personnel, government workers, state health officers, medical society officials, and private physicians. All needed to be considered—but not all were.

The Expected Happened

Proof that the doctors' criticisms were justified came fourteen days after the Public Health Service licensed the vaccine, when polio began to show up in a few children. No one seemed able to say, in clear words that would quiet the alarm, whether such cases—only 114 in 5.5 million by May 31—were coincidental or were the result of live virus in the vaccine.

A careful reading of the Francis report would have shown that among 441,113 youngsters receiving the vaccine in the 1954 trials, sixteen had major reactions, 2,625 had minor reactions, thirty-four developed polio, one died of it, and four died of other causes, all within the first month. *But* the placebo and no-injection control groups had very similar reactions during the same period, including ninety-five cases of polio, three polio deaths, and two deaths from other causes.

This is the kind of information that physicians like to mull over before answering their patients' questions; and it's the kind they should have had. The Francis report, still unread by many doctors, stands as the most anticipated, most talked-about, and *least digested* piece of medical literature in our time.

The Ann Arbor sin, then, was arrogance. The Polio Foundation decided that its judgment was superior to the medical profession's; it took a scientific and a public responsibility into its own hands.

But understanding this doesn't resolve the underlying dilemma: As long as people are motivated less by reason than by emotion, how can a health agency appeal to the public to support worth-while research *without* resorting to ballyhoo and press agentry?

Dr. Ellis D. Sox, San Francisco health director, has remarked of the Salk snafu that "We were all caught in a trap."

We can't afford to get caught again. END

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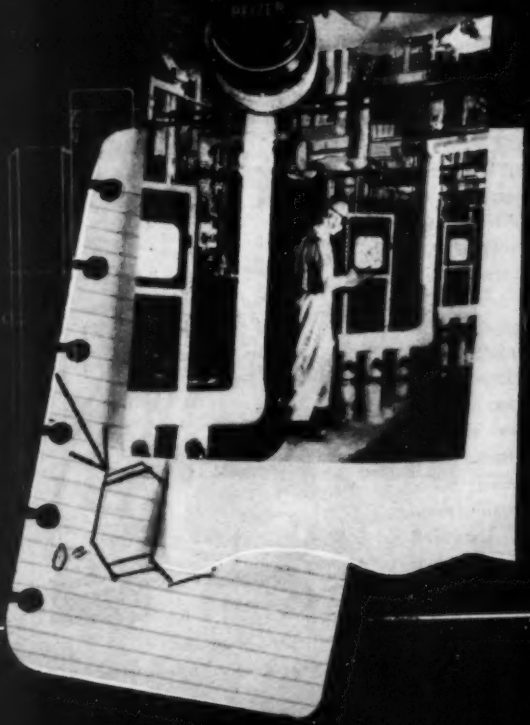

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FERENCES
1. Bunim, J. J., et al.: J.A.M.A. 157:311, 1955. 2. Boland, E. W.: California Med. 82:65, 1955. 3. Norred, S. R.: Am. Prof. Pharm. 21:231, 1955. 4. Waine, H.: Bull. Rheumat. Dis. 5:81, 1955. 5. Herzog, H. L., et al.: Science 121:176, 1955. 6. Spies, T. D. et al.: in press.

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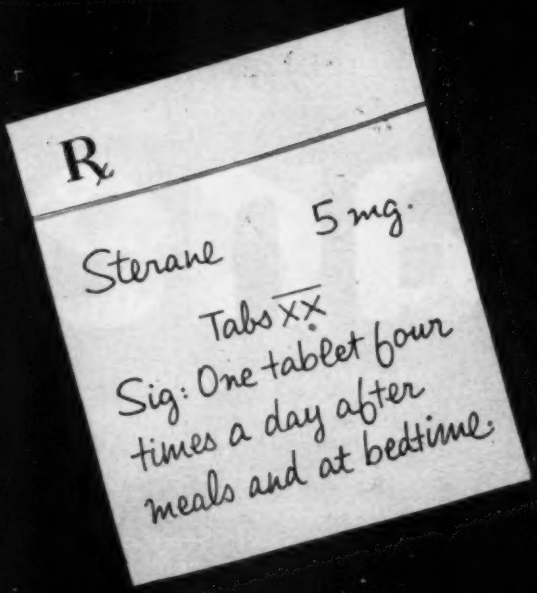

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Thiamine mononitrate (B_1) ..... 25.0 mg.

equivalent to more than 400 eggs

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equivalent to about 14 servings of spinach

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equivalent to almost 4 quarts of milk

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approaches on the wrong side. You throw the child from the path of the car, but you are hit. Can you recover for your injuries?"

The answer: "Yes. You had to act instantly to save the child, and in such situations the law does not expect you to deliberate on your safety."

5. "You are driving a car with defective brakes. A small child darts from behind a parked car into your path and is killed. Are you liable?"

The answer: "No. The proximate cause of the accident was the child's sudden appearance and not your defective brakes."

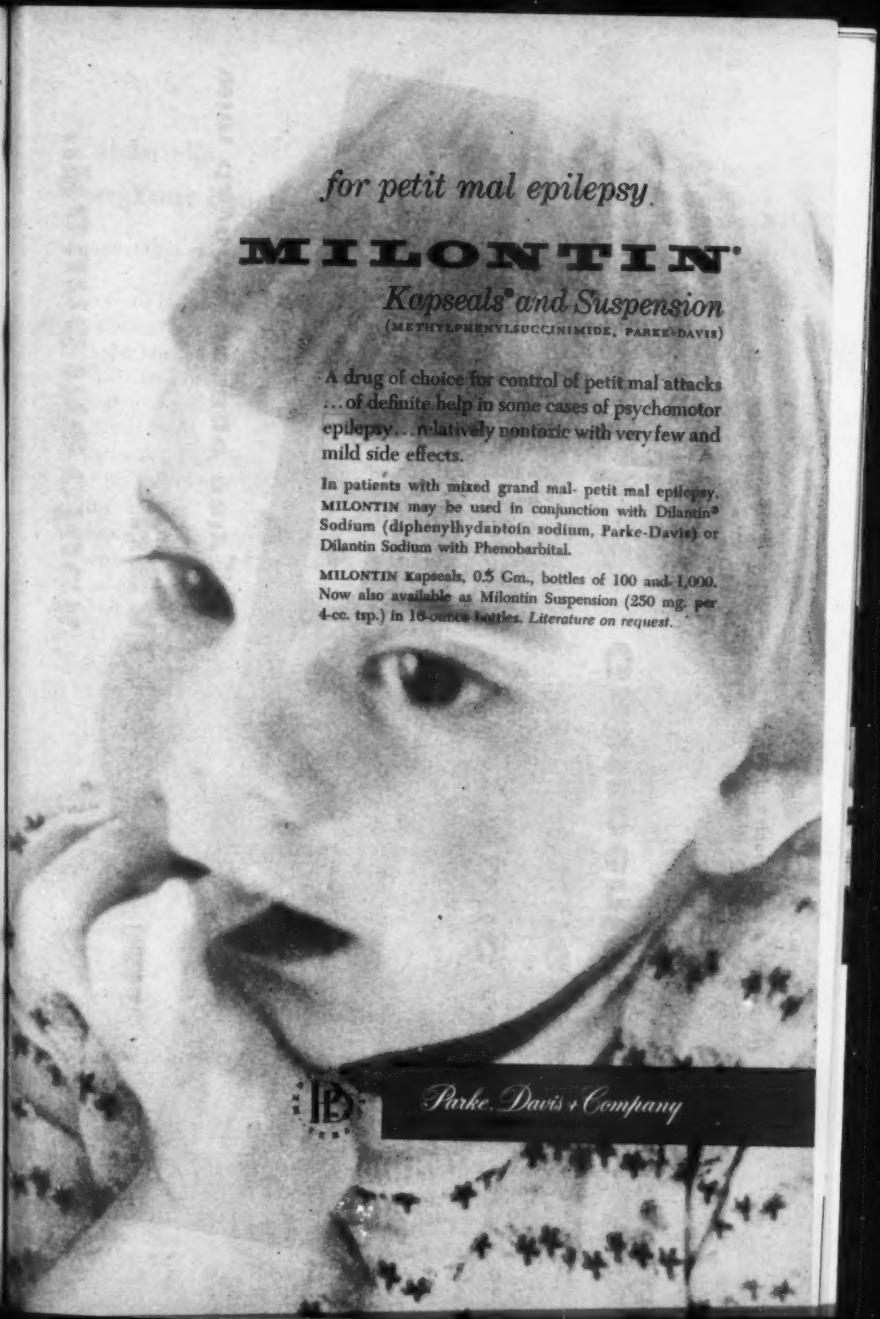
6. "An automobile salesman offers you a ride in a new car to demonstrate its new features. During the drive you are injured in a collision resulting from the salesman's bad driving. Can you recover damages?"

The answer: "Yes. You were not a mere guest in the salesman's car since he was trying to sell it to you. As an invitee, you assumed no risk."

7. "At a baseball game you are seated on the first-base line, which is unprotected by screening. A foul ball strikes you on the temple, and you are severely injured. Can you collect?"

The answer: "No. Foul balls are an obvious risk you must assume when you attend a baseball game."

END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Yardsticks For Your Practice

[CONTINUED FROM 116]

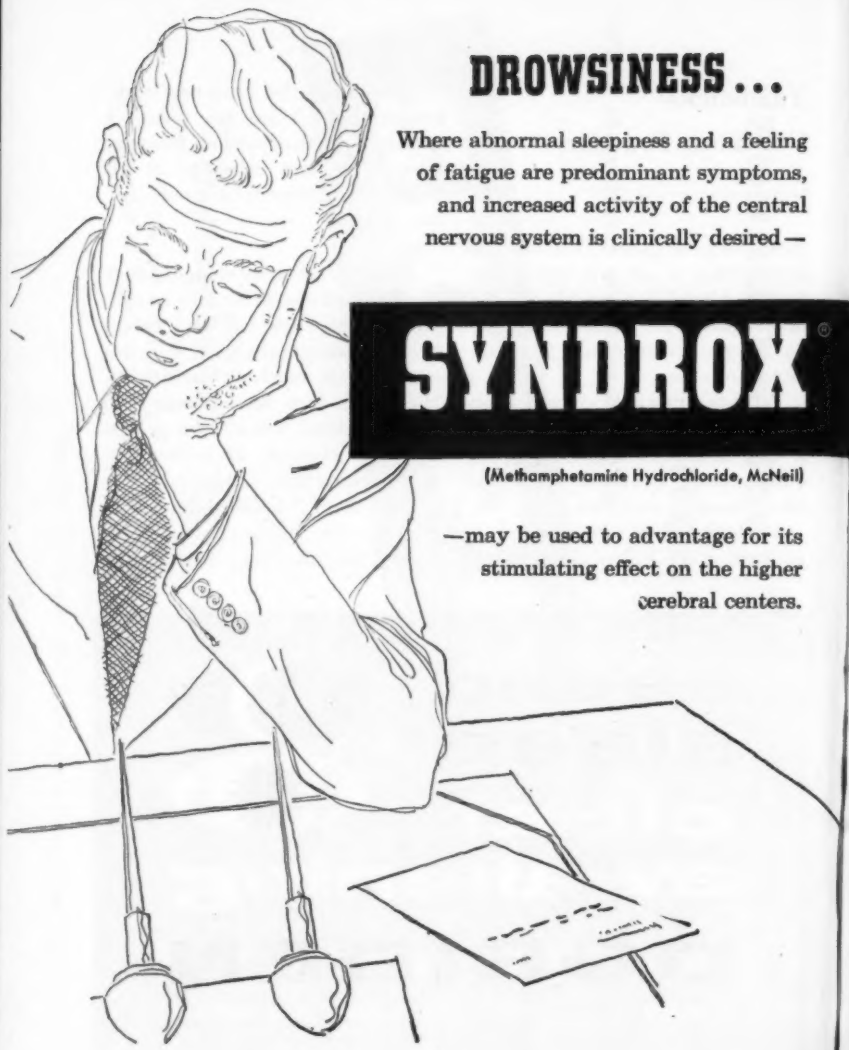
them—all in longhand. The doctor's handwriting is not too legible. In fact, he himself has trouble reading his old case notes. Greater use of the dictating machine would give him clearer records.

Patients' financial records are kept on individual ledger sheets in a ring binder. It's growing quite cumbersome. Eventually it should be replaced by card files.

I note that charge business only is entered on the ledger sheets. Cash business used to be, but a new bookkeeper couldn't see the point. I strongly urge that patients' financial records be kept complete at all times. Partial records have only partial value.

Fees: Dr. Yancey charges $4 for an office visit and $6 for a house call, plus 50 cents a mile one way. I react against mileage charges; they remind me too much of taxi drivers. House-call fees set according to clearly defined zones seem preferable. For example: $6 in town, $8 to the county line, $10 beyond.

Considering his skill and specialty training, Dr. Yancey's fees seem normal for this area. Considering



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—may be used to advantage for its stimulating effect on the higher cerebral centers.

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SYNDROX...

imparts a sense of increased energy and efficiency . . .
elevates the mood (produces euphoria) . . .
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suppresses the appetite.

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INDICATIONS FOR SYNDROX HYDROCHLORIDE:

IN OBESITY...IN MILD DEPRESSION
IN ACUTE AND CHRONIC ALCOHOLISM
IN NARCOLEPSY...IN HYPOTENSION

ADVANTAGES OF SYNDROX HYDROCHLORIDE:

- Rapid onset (10-20 minutes)
- Long duration of effect (6-12 hours, depending on dose)
- Negligible side effects, with proper dosage
- Relatively small dosage

Supplied in 5 mg. tablets (scored, green)—bottles of 100 and 1000. Also available in a pleasant-tasting elixir (colored amber); each 5 cc. (one teaspoonful) containing 5 mg.—pints and gallons. Caution: Use only as suggested.

Samples on request

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the time he spends with each patient, they do *not* seem normal. Some change is necessary to put the practice on a sound economic basis.

It seems to me he has a choice of either raising fees or cutting down time spent per patient. If he raises fees, he's apt to lose some patients. If he cuts down time spent, he's apt to gain some patients. I favor the latter course.

I also favor experimenting with an annual contract for pediatric care. It might appeal to quite a few families on Dr. Yancey's list. For the first year, I suggest a flat charge of $72, payable $6 a month, with an extra charge for treatment of acute illness.

Insurance Claims: As a rule, there's never much insurance work for pediatricians. This practice is no exception.

Appointments: There's a full appointment system; there's also a lot of waiting. Long-winded mothers tend to put the doctor behind time; and, in his own words, he "hasn't the heart to push them through."

He may feel more inclined to do so when he realizes that the average wait in his office is *fifty-five minutes.* This is my own calculation.

Keeping people waiting is no way to build patient satisfaction. It's no way to build a practice, either. Except in emergencies, the schedule

must be maintained, even at the risk of cutting some people short.

Reception of Patients: In the confined space of this reception room, the secretary couldn't possibly ignore patients. But I always think of Dr. Yancey's office as "the one where the girls don't smile."

Phone Technique: Generally good. But both the secretary and the nurse have developed the bad habit of quoting fees for complete courses of treatment to strangers who call up and ask. Such "shoppers" should be invited into the office instead. That's the proper place for such fee discussion.

Major Recommendations: Dr. Yancey has asked whether he should give up his present practice and go into partnership with a better-established man. I think my feelings will be clear from the following comments, written before the partnership question was raised:

This practice has a fine foundation. The doctor has built up a loyal, if not large, following. His aides are competent to handle much more work than they're handling now.

Just two things need to be made available: *more well-laid-out space* and *more of the doctor's time*. Given these things, this practice can grow. And all concerned are bound to profit. END

invitation to asthma?

not necessarily . . .

Tedral, taken at the first sign of attack, often forestalls severe symptoms.

relief in minutes . . . Tedral brings symptomatic relief in a matter of minutes. Breathing becomes easier as Tedral relaxes smooth muscle, reduces tissue edema, provides mild sedation.

for 4 full hours . . . Tedral maintains more normal respiration for a sustained period—not just a momentary pause in the attack.

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Theophylline	2 gr.
Ephedrine HCl	⅜ gr.
Phenobarbital	⅛ gr.

in boxes of 24, 120 and 1000 tablets

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Myths About Admissions To Medical School

[CONTINUED FROM 159]

only consideration for admission.

To show that Harvard is not alone in this attitude: Dr. Coggeshall, who heads the School of Medicine at the University of Chicago, cites similar policies there. In a recent issue of his school's medical alumni bulletin, he says: "Although scholastic achievement as measured by grades is taken into consideration, it is far from the sole criterion."

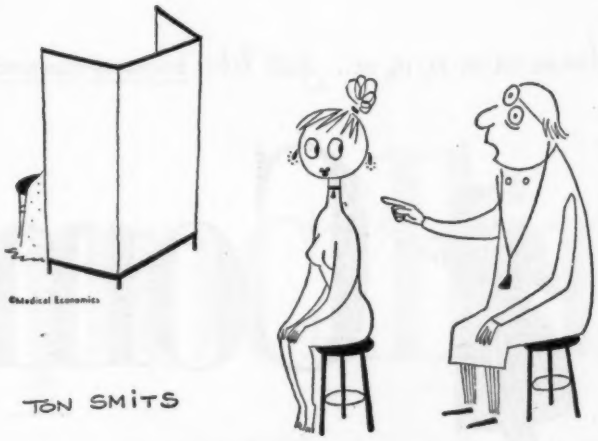
It's the "most common" of "many exaggerated rumors," he adds, that there's no consideration for the applicant with less than "a straight-A record." And he refutes the "rumor" with the following fact:

"We now have several students who in their early collegiate years did rather poorly in their scholastic work. But after they demonstrated that they could do well . . . their earlier poor standing did not bar them from admission."

Four-Letter Men Only?

Myth: Only the leader in extracurricular activities has a chance.

Fact: To be sure, such activities help; they indicate that an applicant isn't just a bloodless grind. Still, says Dr. Funkenstein, there were four or five men in last year's entering class at Harvard who had apparently



"Your slip is showing."

gone out for *no* significant undergraduate extra-curricular activities.

And "if participation in varsity athletics, presidencies . . . and editorships . . . are used as evidence of *leadership*," he adds, the following figures certainly belie the myth: Thirty-nine per cent of the young people who entered the Harvard Medical School in 1954 showed leadership in no activities; 39 per cent, leadership in one activity; 21 per cent, leadership in two activities; only 1 per cent, leadership in three activities.

Myth: The applicant must have top recommendations from his college.

Fact: In last year's entering class at Harvard Medical School, 17 per cent of the students had been described by their colleges as "less than excellent." Comments the doctor: "In many cases in which there was a disparity in the letters received about a man, his college was contacted for additional information. The weight assigned to letters of recommendation is often dependent on the committee's experience with the writers."

Myth: The personal interview at the medical school is the real basis for selection.

Fact: About 25 per cent of last year's successful applicants to Harvard were placed by one or more interviewers in what Funkenstein

calls "less than the top category." Often, when the interviewers get differing impressions of a man, they try to have him talk with additional members of the committee. They're all aware, the doctor explains, that you can't evaluate a person securely on the basis of an hour's interview.

Myth: Even a good student's chance of admission to medical school is small because of the large number of applicants in relation to available openings.

Fact: Speaking generally, nothing could be further from the truth. The number of applicants to U.S. medical schools, Dr. Funkenstein points out, has been declining steadily for six years. In 1949, there were about 24,000 applicants. In 1951, there were fewer than 20,000. In 1953, there were only about 14,700. If this "alarming" shrinkage continues, he says, there soon won't be enough medical students to go around.

This view is shared by Dean Coggeshall, who recalls that in 1947 there were as many as 2,300 applicants for seventy-two openings in Chicago's medical school. Today, he insists, "the situation is much different."

Some two-year schools, he points out, have become four-year schools; most of the schools have increased their enrollments; and the residue of returning veterans has practically disappeared. As a result of such de-

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DOSAGE: 1 to 2 tablespoonfuls on arising, repeated every three hours or whenever nausea threatens.

IMPORTANT: EMETROL must always be taken *undiluted.* Fluids should not be allowed for at least 15 minutes after each dose.

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In epidemic vomiting (acute infectious gastroenteritis, intestinal "flu"), EMETROL works rapidly, even in refractory cases; control is usually established with the first few doses, "often with a single dose."[2]

1. Crunden, A. B., Jr., and Davis, W. A.: *Am. J. Obst. & Gynec.* 65:311, 1953. 2. Bradley, J. E., et al.: J. Pediat. 38:41, 1951. 3. Tebrock, H. E., and Fisher, M. M.: *M. Times* 82:271, 1954.

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velopments, he says, a "well-qualified student" has "almost no difficulty" getting into medical school.

To sum up, it's certainly true that high grades, top recommendations, a healthy interest in extracurricular activities, and a frank delight in science are assets for the youngster who wants to become a doctor. But these are by no means the sole requirements; they will not of themselves assure your son's entrance into medical school.

In considering an applicant, the modern admissions committee looks for breadth of vision, creative imagination, character, integrity, capacity for growth, innate warmth, emotional maturity, and capacity for leadership. And without in any way deprecating the sciences, Dr. Funkenstein, for one, believes that such qualities are best brought to early fruition through a broad liberal education.

Your son's premedical career, therefore, need not be a "rat race." He needn't be a grind, isolated from the main currents of college life.

"Medicine," in the Harvard physician's view, "is rapidly shifting from the 'patient as a disease' to the 'patient as a human being.'" It's not that "we are becoming less scientific," he says, but that medical men are on the way to understanding that science without humanity isn't enough. END

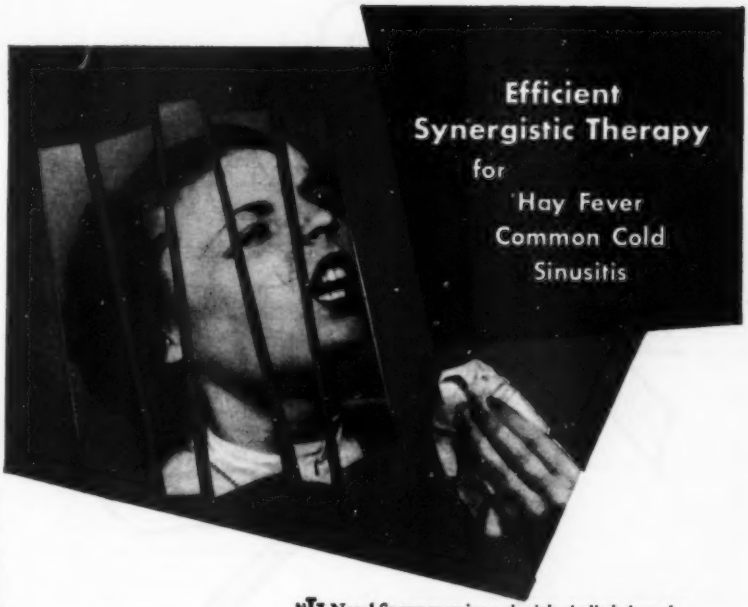
G.P. Hospital Rejects Blue Cross

[CONTINUED FROM 141]

The reply: The plan's certificate spells out in detail the differing benefits given subscribers who go to Blue Cross and to non-Blue Cross hospitals. And Blue Cross gives each new subscriber a leaflet that summarizes the benefits described in the more lengthy certificate.

The charge: In addition to its shocking disregard for the family doctor, Blue Cross is guilty of financial policies that are grossly unfair to hospitals. Especially reprehensible is its contract under which member-hospitals agree to make refunds to the plan (as Kenner Hospital had to do) when their income exceeds their operating costs by more than a certain percentage.

The reply: Only Kenner Hospital—of the 225 Blue Cross member-institutions in Illinois—has ever called the contract in question unfair financially. Furthermore, of the $33,000,000 the plan paid to Illinois hospitals in 1953, less than one-half of 1 per cent had to be returned as excess charges. But in the case of Kenner Hospital, the excess that had to be returned to Blue Cross was 17 per cent of the amount originally paid to the institution. END



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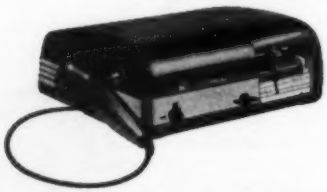

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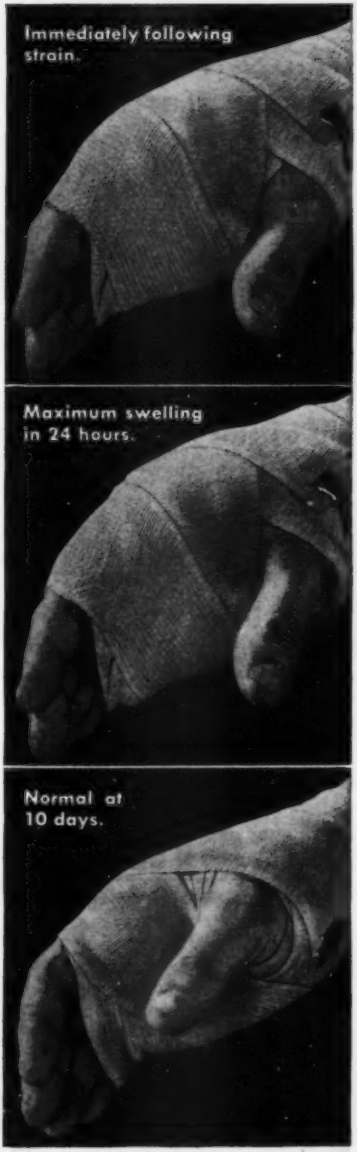

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Memo

FROM THE PUBLISHER

Something Different

Concise, original articles have always been MEDICAL ECONOMICS' stock in trade. They still are. But last month we published a piece that violated at least three of our usual rules. Specifically:

¶ It wasn't at all concise. In fact, it totaled 7,500 words.

¶ It wasn't originally written for MEDICAL ECONOMICS. Instead, it was a condensation.

¶ It wasn't even an article, in the usual sense, but verbatim excerpts from an A.M.A. report.

As you've probably gathered by now, we're talking about "The A.M.A. Report on Unethical Practices." How did we happen to publish such an unorthodox piece? And why do we consider it a perfect illustration of our proper editorial function—the three broken rules notwithstanding?

Here's the story behind the story:

Late in 1953, the A.M.A. House of Delegates authorized a special committee to search out the basic causes of fee splitting and other unethical practices, which were then very much in the news. Seven distinguished doctors were given this assignment. They spent nearly $15,000 on research, pondered deeply over the results, and turned in their report on November 18, 1954.

The report turned out to be something of a hot potato. It was loaded with constructive comment on the relative values of fees, the competition for surgical work, the restrictions imposed by specialty boards, and such. But it was also sprinkled with quotes from people interviewed that were vividly critical of doctors. So the problem facing medicine's policy-makers was this:

How to get the good stuff to the doctors without having the bad stuff used against them?

One way soon became apparent. That was to release the report through independent professional channels, where it would cause less public stir than through official channels. Realizing this, several responsible doctors made the report available to MEDICAL ECONOMICS.

We prepared our own condensation. But we let all interested parties know what we were doing, and they tacitly approved. Initial publication under such circumstances was clearly preferable to the headline hoopla of a general release.

Something different? Yes, in a way, this story was. Yet it typifies the one rule that hasn't changed in MEDICAL ECONOMICS' nearly thirty-two years. That rule is:

To print facts as we find them, both favorable and unfavorable, as long as the profession as a whole stands to benefit.—LANSING CHAPMAN

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